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Introduction

The *Texas Medicaid Service Delivery Guide* is provided as a guide to Medicaid providers. Its purpose is to give health and health-related providers information regarding Medicaid medical and dental policies, key public health department contacts, suggested forms for chart documentation, and cross references to the *Texas Medicaid Provider Procedures Manual*.

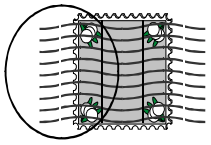
The information in the *Texas Medicaid Service Delivery Guide* at times duplicates information in the *Texas Medicaid Provider Procedures Manual* to ensure that providers and billing and coding personnel have the same reference material. However, most of the information in the two volumes is different because of the intended audiences; and therefore, the two volumes are generally meant to be complementary.

Additionally, users of both volumes are encouraged to read the bimonthly *Texas Medicaid Bulletin*, which includes timely updates on both new and revised medical and dental policies, as well as educational, billing, and coding information.

As the Texas Medicaid Program continues to roll out Medicaid Managed Care Projects in various Service Delivery Areas (SDAs) of the State, it is also critical for readers to understand that reimbursement methods/plans may vary. Thus, providers and administrative personnel will find detailed information of the Medicaid program in the above-referenced publications. However, if providers are serving Medicaid-eligible persons who are enrolled in a STAR Medicaid Managed Care Organization (MCO), then it is important for them to check the MCO's Provider Manual for additional information concerning billing and contractual requirements within each plan.

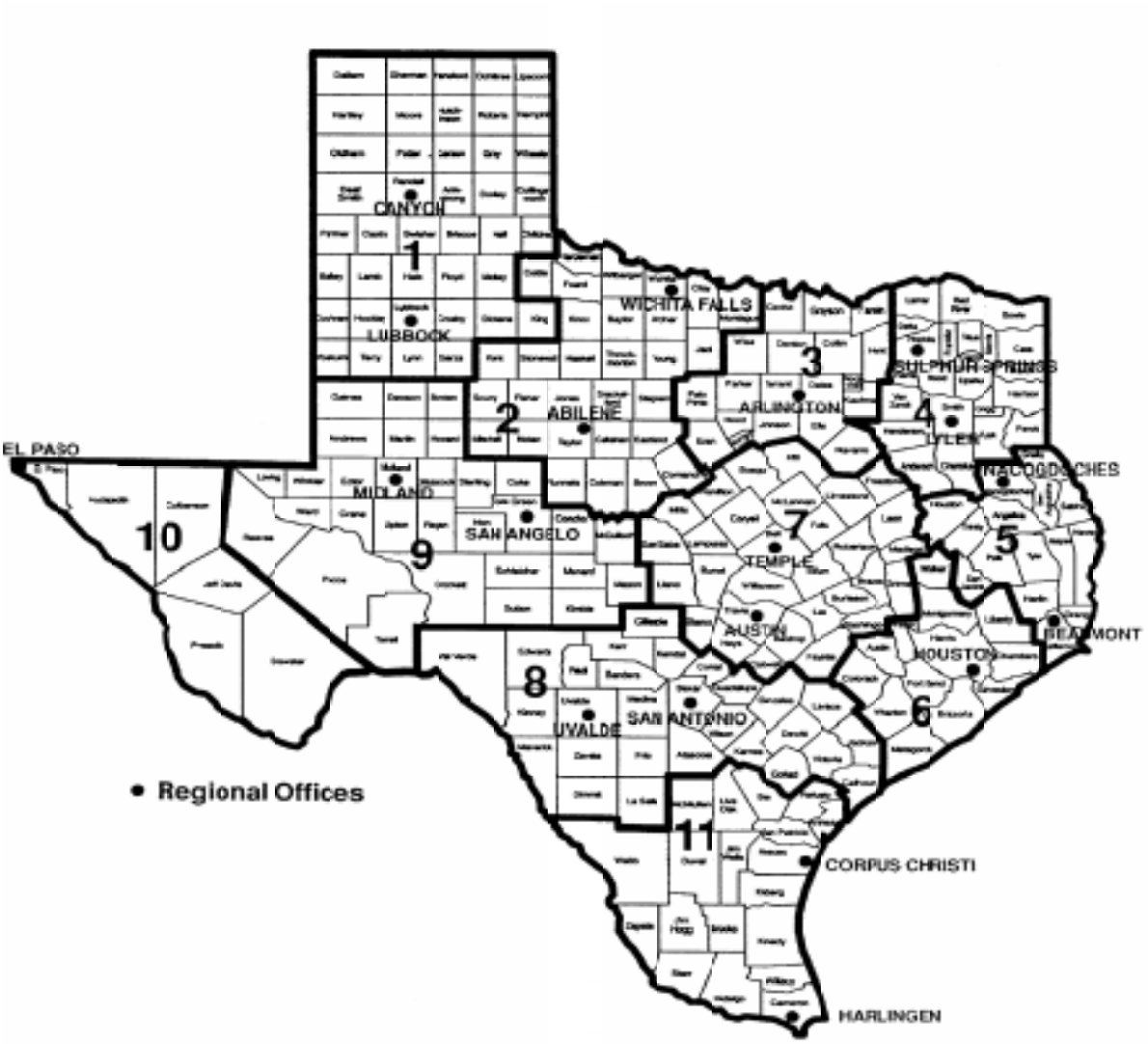
1

Communication Directory



Communication Directory

1.1 TDH Public Health Regions Map



1.2 Federal and State Telephone Numbers

Telephone Number	Department/Programs
800-342-AIDS	AIDS Hotline (Nationwide, distributed by CDC-Centers for Disease Control, Atlanta, Georgia)
800-299-2437	HIV/STD InfoLine
800-255-1090	Texas HIV Medication Program
800-252-5400	Child/Elder Abuse Intake (DPRS)
512-458-7420	Children's Vision Program (TDH)
410-290-5850	CLIA Hotline CLIA Provider Registration/Certification (Refer to the "Health Facility Licensure and Certification Division" list in this Appendix section of the manual)
202-783-3238	CLIA Regulations (U.S.Govt. Printing Office)
800-458-9858	Client Abuse Hotline for Nursing Facilities (TDHS)
800-252-8263	Client Inquiry Hotline (TDH) (Medicaid questions from clients with Medicaid only)
303-355-4729	Denver Development Materials (DDM)
512-458-7745	THSteps Program (TDH)
512-458-7661 FAX: 512-458-7672	Laboratory Supply Orders (TDH)
512-458-7680 512-458-7578	Interpretation of Lab Results (TDH) Report of Lab Results (TDH)
210-534-8857 ext 2357	Adolescent Preventive Visit Pap Smear Supplies/Forms Texas Center for Infectious Disease (Women's Health Laboratories)
512-458-7444	Family Planning Program
512-424-6519	Fraud or Abuse of Provider Services (THHSC Office of Investigations and Enforcement)
512-458-9858	Fraud or Abuse/Nursing Facilities/DHS
800-252-8011	Fraud or Abuse/Client/DHS
800-792-1109	Goal-Directed Therapy
512-450-3750	Hospice Program (TDHS Policy Development division)
800-252-9152	Immunization Division (TDH)
512-794-6862	Managed Care (LoneSTAR Health Initiative or STAR Health Plan) - TDH
512-338-6512	Medically Needy Spenddown Unit (TDH)
800-442-2620	Medicare/Social Security Administration
512-458-7700	Newborn Screening (TDH)
512-458-7724	Program for Amplification of Children of TX (PACT) (TDH)
800-252-8141 or 512-338-6576	Recipient Utilization Control Unit (TDH) (For Lock-In status review and for referrals from providers for potential client overutilization, etc.)
713-526-2559	Snellen Letter ("Tumbling E" Wall Chart)
512-458-7111 ext. 2867	Texas Pre-School Screening Inventory (TPSI) Worksheets and Manuals
512-338-6937	Utilization Review/TDHS
800-435-4165 or 512-338-6962	Vendor Drug Program (TDH) (Specifically for pharmacy use)

1.3 TDHS Regional Offices and Administrators

Region	Administrator/Address	Telephone/FAX	RA Secretary
01	Barry Fredrickson 2109 Avenue Q PO Box 10528 Lubbock TX 79408	806-472-2502 FAX: 806-472-2503	Marilyn Pierce
02/09	David Maberry 4380 Spindle Top PO Box 6635 Abilene TX 79608	915-695-5750 FAX: 915-695-3324	Laverne Laird
03	Alvin Johnson 631-106th Street PO Box 5128 Arlington TX 76011	817-640-5090 FAX: 817-695-5860	Rosie Ramirez
04	Sammie Bedford 302 East Rieck Road Tyler TX 75703	903-561-5359 FAX: 903-509-5133	Cindi Hurst
05	Melanie Muse 285 Liberty PO Box 4906 Beaumont TX 77701	409-835-3751 FAX: 409-880-3209	Carol Rice
06	Mamie Ewing 5425 Polk Ave. PO Box 16017 Houston TX 77222-6017	713-767-2401 FAX: 713-767-2419	Eunice Sanchez
07	Barry Fredrickson 7901 Cameron Road Building 2 PO Box 15995 Austin TX 78761	512-832-7656 FAX: 512-834-3459	Sherry Kothe
08	David C. Trejo 11307 Roszell PO Box 23990 San Antonio TX 78223-0990	210-337-3271 FAX: 210-337-3405	Irma Sleighter
10	Tony Franco 1200 Golden Key Circle PO Box 10276 El Paso TX 79994	915-599-3742 FAX: 915-599-3709	Peggy Wright
11	Paul Ebrom 2520 North Closner PO Box 960 Edinburg TX 78539	210-316-8203 FAX: 210-316-8355	Rachel Hinojosa

Refer to "TDH Public Health Regions Map" on page 1-3 to identify the regional boundaries.

1.4 TDHS Contract Manager Staff for Medicaid Eligibility Outstation Workers

Region	Contact	Telephone Number
1	Annie Gober	806-472-2508
2/9	Mary Evans	817-720-8434
3	Suzie Peterson	214-630-4411 ext 277
4	Kathy Knight	903-581-9243
5	Lynne Haynes	409-880-3490
6	Bob Nix	713-696-7171
7	Mike Blackard	512-834-3312
8	Daniel Lopez	210-619-8041
10	Judy Walker	915-599-3627
11	Javier Gonzalez	210-316-8302

1.5 TDH Public Health Region Contacts

Public Health Region 1

Regional Office (Lubbock)

Texas Dept. of Health/PHR 1
1109 Kemper
Lubbock TX 79403
806-744-3577 FAX: 806-741-1366

Public Health Director
Charles E. Bell, MD

Asst. Regional. Director. for Admin.
Bryce McGregor

Dir. of Social Work Services
Kathy Thomas

Immunization Program Manager
Shirley Richardson

Tuberculosis Program Manager
Diane McDonald, RN

THSteps Program Manager
Beverly Ham
1109 Kemper
Lubbock TX 79403
806-767-0350

Medical Transportation Manager
Beverly Ham
1109 Kemper
Lubbock TX 79403
806-767-0350

TDH Regional Family Planning Specialist
Patricia Rennie
1101 Camino La Costa
Austin TX 78752
512-467-9875 FAX: 512-451-1468

Public Health Regions 2 & 3

Regional Office (Arlington)

Texas Dept. of Health/PHR 2 & 3
1351 East Bardin
Arlington TX 76017
817-264-4000 FAX: 817-264-4455

Public Health Director
James A. Zoretic, MD

Asst. Reg. Dir. for Admin.
William F. Harris

Dir. of Social Work Services
Bill Creel

Director of Family Health Services
(Vacant)

Immunization Program Manager
Elizabeth (Becky) Cook

Communicable Disease Program Manager
Shirley H. Cummings, RN

Tuberculosis Program Manager
Shirley H. Cummings, RN

THSteps Program Manager
Georgette Boozer
817-264-4251

Medical Transportation Manager/PHR 2
Sue Henderson
1290 South Willis, Suite 100
Abilene TX 79605
915-690-3261

Medical Transportation Manager/PHR 3
Barbara Columbus
Box 181869 MC 73
Arlington TX 76096-1869
817-264-4583

THSteps Regional Program Specialist/PHR 2
Jeannette Davis
Pat Snell
1290 S. Willis, Suite 100
Abilene TX 79605
915-690-4406

TDH Regional Family Planning Specialist
Floyd Dixon
1351 East Bardin Road RM 315-#62
Arlington TX 76081
817-264-4456 FAX: 817-264-4455

Public Health Region 4 & 5 (North)

Regional Office (Tyler)

Texas Dept. of Health/PHR 4 & 5 North
1517 West Front St.
Tyler TX 75702
903-595-3585 FAX: 903-593-4187

Public Health Director
Dr. Paul K. McGaha, DO, MPH

Asst. Reg. Dir. for Admin.
Rebecca Berryhill

Dir. of Social Work Services
Barbara Brandon, LMSW-ACP

Director of Nursing
Sharon Flournoy, RN, MSN

Immunization Program Manager
Harold Higgins

Communicable Disease Program Manager
Richard Hensley

Tuberculosis Program Manager
Celia Robinson, RN

THSteps Program Manager
Barbara Brandon, LMSW-ACP
903-595-3585

Medical Transportation Manager/PHR 4
Jess Reeves
1517 W. Front Street
Tyler TX 75702
903-533-5399

TDH Regional Family Planning Specialist
June Cumberland
5425 Polk Ave., Suite J
Houston TX 77023
713-767-3124 FAX: 713-767-3165

Public Health Region 5 & 6 (South)

Regional Office (Houston)

Texas Dept. of Health 5 & 6 South
5425 Polk Ave. #J
Houston TX 77023
713-767-3000 FAX: 713-767-3049

Public Health Director
Dr. H. Mark Guidry, MD, MPH

Deputy Reg. Dir. For Admin.
Greta Etnyre

Dir. of Social Work Services
Sam Cooper, LMSW

Director of Nursing
Sandy O'Keefe, RN, MPH

Immunization Program Manager
Alkarim Kanji, BS, RN, RRA

Communicable Disease Program Manager
(Vacant)

Tuberculosis Program Manager
Syed Haidry, MD, MPH

THSteps Program Manager
Judith Morris, LMSW-ACP
713-767-3101

Medical Transportation Manager/PHR 6
Judy Terry
5425 Polk Ave., Suite J
Houston TX 77023-1497
713-767-3136

Medical Transportation Manager/PHR 5S/5N
Deborah Bellard
3420 Fannin
Beaumont TX 77701
409-838-7178

TDH Regional Family Planning Specialist
June Cumberland
5425 Polk Ave., Suite J
Houston TX 77023-1497
713-767-3124 FAX: 713-767-3125

Public Health Region 7

Regional Office (Temple)

Texas Dept. of Health/PHR 7
2408 S 37th St
Temple TX 76504-7168
254-778-6744 FAX: 254-778-4066

Public Health Director
James Morgan, MD, MPH

Deputy Reg. Dir. for Admin.
Thomas W. Bever, Jr.

Dir. of Social Work Services
Leslie Anderson

Director of Nursing
Linda Breeden, RN, MS

Immunization Program Manager
Maribeth Bartz

Communicable Disease Program Manager
Charles T. Lee

Tuberculosis Program Manager
Dana Schoepf, RN

THSteps Program Manager
Leslie Anderson

Medical Transportation Manager/PHR 7
Guadalupe Sosa
1101 Camino La Costa Suite 210
Austin TX 78752-3930
512-467-9875 ext 229

TDH Regional Family Planning Specialist
Patricia Rennie
1101 Camino La Costa
Austin TX 78752
512-467-9875 FAX: 512-451-1468

Public Health Region 8

Regional Office (San Antonio)

Texas Dept. of Health/PHR 8
7430 Louis Pasteur Drive
San Antonio TX 78229
210-949-2000 FAX: 210-949-2010

Public Health Director
William S. Riggins, MD, MPH

Asst. Reg. Dir. for Admin.
Anita Martinez

Dir. of Social Work Services
Edward Spiller

Director of Nursing
Charlene Prescott, RN, MPH

Immunization Program Manager
Laurie Henefey

Communicable Disease Program Manager
Mary Martinez

HIV/STD Program Manager
Deborah Mayhew

Tuberculosis Program Manager
Mary Martinez

THSteps Program Manager
Sheryl Shudde

Medical Transportation Manager/PHR 8
Guadalupe M. Reyes
7430 Louis Pasteur Drive
San Antonio TX 78229
210-949-2021

TDH Regional Family Planning Specialist
Joyce Valadez
7430 Louis Pasteur Drive
San Antonio TX 78229
210-949-2081 FAX: 210-949-2010

Public Health Region 9 & 10

Regional Office (El Paso)

Texas Dept. of Health/PHR 9 & 10
6070 Gateway East, Suite 401
PO Box 9428
El Paso TX 79984-0428
915-774-6200 FAX: 915-774-6280

Public Health Director
Miguel Escobedo, MD, MPH

Asst. Reg. Dir. for Admin.
Demetrio Gutierrez

Dir. of Social Work Services
Lois Flynn

Director of Nursing
Gloria Miller, RN

Immunization Program Manager
Efren Ornelas

Communicable Disease Program Manager
Efren Ornelas

Tuberculosis Program Manager
Claudia Turner, RN

THSteps Program Manager
Lois Flynn
915-774-6227

THSteps/Medical Transportation Program Director/
PHR 9 & 10
Marta Saldana
PO Box 9428
El Paso TX 79984
915-774-6287

TDH Regional Family Planning Specialist
Patricia Rennie
1101 Camino La Costa
Austin TX 78752
512-467-9875 FAX: 512-451-1468

Public Health Region 11

Regional Office (Harlingen)

Texas Dept. of Health/PHR 11
601 W. Sesame Drive
Harlingen TX 78550
956-423-0130 FAX: 956-412-3915

Public Health Director
Brian Smith, MD, MPH

Asst. Reg. Dir. for Admin
Sylvia Garces-Hobbs

Dir. of Social Work Services
R. Scott Horney

Director of Nursing
Sister Mary Nicholas Vincelli, RN, MSN

Immunization Program Manager
Ivette Nunez

Communicable Disease Program Manager
Brian R. Smith, MD, MPH

HIV/STD Program Manager
Paul Popete

THSteps Program Manager
Russell Armstrong
956-444-3257

Medical Transportation Manger/PHR 11
Carlos De La Rosa
600 South Bicentennial
McAllen TX 78501
956-971-1279

TDH Regional Family Planning Specialist
Joyce Valadez
7430 Louis Pasteur Drive
San Antonio TX 78229
210-949-2081 FAX: 210-949-2010

1.5.1 TDH Public Health Nutrition Program

1.5.1.1 Central Office:

Claire Heiser, MS, RD, LD
Chronic Disease Nutrition Consultant

Sherry Clark, MPH, RD, LD
Public Health Nutrition Coordinator

Barbara Keir, MA, RD, LD
Director, Division of Public Health Nutrition and Education

Mimi Kaufman, MPH, RD, LD
CSHCN Nutrition Consultant

Roxanne Robinson, RD, CS, LD
CSHCN Nutrition Consultant

PHR	Regional Nutritionist	MCH Nutritionist	Chronic Disease Nutritionist
1	Lawrence Headley, RD, LD TDH 1109 Kemper Lubbock TX 79403 806-767-0463 FAX: 806-741-1366		Camille Joy, RD, LD - TDH 1109 Kemper Lubbock TX 79403 806-767-0418 FAX: 806-741-1366
2/3	Cheryl Brien-Warren, RD, LD TDH PO Box 181869 Arlington TX 76096-1869 817-264-4380 FAX: 817-264-4378		Jane Schwarz, RD, LD TDH PO Box 181869 Arlington TX 76096-1869 817-264-4000 ext 2370 FAX: 817-264-4378
4/5 North	Gretchen Stryker, RD, LD TDH 1517 West Front Street Tyler TX 75702 903-533-5315 FAX: 903-593-4187	Susan Bennett, RD, LD and Drue M. Evans, RD, LD TDH 1517 West Front Street Tyler TX 75702 903-533-5315 FAX: 903-593-4187	Edee Crosman, MEd, RD, LD TDH 1517 West Front Street Tyler TX 75702 903-533-5376 FAX: 903-593-4187
5/6	Dianne Gertson, RD, LD, MBA TDH 5425 Polk Avenue, Suite J Houston TX 77023-1497 713-767-3483 FAX: 713-767-3483		Lois Grant TDH 5425 Polk Avenue, Suite J Houston TX 77023-1497 713-767-3230 FAX: 713-767-3889
7	Linda Garriott, MS, RD, LD TX Department of Health 1200 Avenue K, Suite 200 Marble Falls TX 78654 210-693-8328 FAX: 210-693-8031		
8	Rosario Hamilton, RD, LD TX Department of Health 7430 Louis Pasteur Drive San Antonio TX 78229 210-949-2043 FAX: 210-949-2084		Janice Brister, LD TX Department of Health 7430 Louis Pasteur Drive San Antonio TX 78229 210-949-2044 FAX: 210-949-2084
9/10	Chester Bryant TX Department of Health PO Box 9428 El Paso TX 79984-0428 915-774-6224 FAX: 915-774-6280		
11	Akin Popoola, MS, RD, LD TX Department of Health 604 West Sesame Drive Harlingen TX 78550 956-423-0130 ext 660 FAX: 956-423-0130		(vacant) TX Department of Health 604 West Sesame Drive Harlingen TX 78550 956-423-0130

1.6 State Participating Local Health Departments and Public Health Districts

Abilene Public Health Department / Region 2/3
Larry Johnson, Administrator
PO Box 6489 (79608-6489)
2241 South 19th Street
Abilene TX 79605
915-692-5600 FAX: 915-690-6707

Andrews City-County Health Department / Region 9/10
Robert Garcia, MD, Director
211 North West 1st Street
Andrews TX 79714
915-524-1434 FAX: 915-524-1461

Angelina County & Cities Health Dist. / Region 4/5N
Kevin Collins, Administrator
Royce Read, MD, Director
Lufkin TX 75901
409-632-1372 FAX: 409-632-2640

Atascosa County Health Department / Region 8
Gerald B. Phillips, MD, Director
1102 Campbell Avenue
Jourdanton TX 78026
210-769-3451 FAX: 210-769-2349

Austin Department of Health & Human Services / Region 7
Health District
David Lurie, Director
2100 E. St. Elmo, Bldg. E
Austin TX 78744
512-707-3220 FAX: 512-707-5404

Beaumont City Health Department / Region 5/6 S
Ingrid West-Holmes, Director
H. Mark Guidry, MD, MPH
PO Box 3827 (77704)
950 Washington Blvd.
Beaumont TX 77705
409-832-4000 FAX: 409-832-4270

Bell County Public Health District Region 7
Wayne Farrell, Director
PO Box 3745 (76505)
South 9th Street
Temple TX 76501
254-778-4766 FAX: 254-778-8251

Brazoria County Health Department/Region 6/5 S
Leo D. O'Gorman, MD, Director
432 East Mulberry
Angleton TX 77515
409-849-5711 FAX: 409-849-0159

Brazos County Health Department / Region 7
Ken Bost, Executive Director
201 North Texas Avenue
Bryan TX 77803-5317
409-361-4440 FAX: 409-823-6993

Brownwood-Brown County Health Department / Region 2/3
Gary Butts, City Manager
PO Box 1389
Brownwood TX 76804
915-646-0554 FAX: 409-823-6223

Calhoun County Health Department/Region 8
Laine Benson, MD, Director
117 West Ash
Port Lavaca TX 77979
512-552-9721 FAX: 512-552-9722

Cameron County Health Department / Region 11
Rolando Martinez, Administrator
186 North Sam Houston Blvd.
San Benito TX 78586
956-399-0185 FAX: 956-399-0183

Cass County Health Department / Region 4/5 N
R. Bruce LeGrow, MD, Director
PO Box 310 (75563)
South Kaufman and Rush
Linden TX 75563
903-756-7051 FAX: 214-796-3976

Chambers County Health Department / Region 6/5 S
Leonidas S. Andres, MD, Director
PO Box 670 (77514)
1222 Main Street
Anahuac TX 77514
409-267-6679 FAX: 409-267-3962

Cherokee County Health Department / Region 4/5 N
Austin A. Weaver, MD, Director
1209 N. Main Street
Rusk TX 75785
903-683-4688 FAX: 903-683-2393

City of Dallas Dept. of Environmental & Health Services/Region 2/3
Beverly J. Weaver, Director
1500 Marilla Street, Suite 7AN
Dallas TX 75201
214-670-5216 FAX: 214-920-7976

City of Laredo Health Department / Region 11
Jerry Robinson, Director
PO Box 2337 (78044)
2600 Cedar Street
Laredo TX 78040
956-723-2051 FAX: 956-726-2632

Collin County Health Care Services / Region 2/3
Bob Lindberg, Director
825 North McDonald Street
McKinney TX 75069
214-548-5500 FAX: 214-548-7221

Corpus Christi-Nueces County Public Health District/Region W
Nina M. Sisley, MD, Director
PO Box 9727 (78469)
1702 Horne Road
Corpus Christi TX 78416
512-851-7200 FAX: 512-851-7295

Corsicana-Navarro County Public Health District/Region 2/3
J.H. Barnebee, MD, Director
PO Box 518 (75110)
508 North Main, Corsicana TX 75110
903-874-6731 FAX: 903-872-7215

Cuero-DeWitt County Health Department / Region 8
Lanie Benson, MD, Director
106 North Gonzales Street
Cuero TX 77954
512-275-3461 No FAX

Dallas County Health Department / Region 2/3
James R. Farris, MD, Director
2377 Stemmons Freeway
Dallas TX 75207-2710
214-819-2103 FAX: 214-819-2107

Del Rio-Val Verde County Health Department
Lawrence O'Brien, MD, Director
200 Bridge
Del Rio TX 78840
210-774-8701 FAX: 210-774-8795

Denton County Health Department / Region 2/3
Bing Burton, Administrator
306 N. Loop 288, Suite 183
Denton TX 76201
940-565-8569 FAX: 940-565-8621

Ector County Health Department / Region 9/10
Clyde S. Patterson, MD, Director
221 North Texas
Odessa TX 79761
915-335-3141 FAX: 915-335-3112

El Paso City-County Health and Environmental District/Region 9/10
Laurance N. Nickey, MD, Director
1148 Airway Blvd.
El Paso TX 79925-3692
915-771-5701 FAX: 915-543-3541

Fort Bend County Health Department/Region 6/5 S
James Robertson, MD, Interim Director
Jean Galloway, MD, Director
PO Box 668 (77471)
3409 Avenue F
Rosenberg TX 77471
713-342-6414 FAX: 713-342-7371

Forth Worth-Tarrant County Dept. of Public Health/Region 2/3
Bob Galvan, Director
Nick Curry, MD, Director
1800 University Drive
Fort Worth TX 76107
817-871-7237 FAX: 817-871-7335

Galveston County Health District/Region 6/5 S
Ralph D. Morris, MD, MPH, Director
PO Box 939 (77568)
1207 Oak Street
La Marque TX 77568
409-938-7221 FAX: 409-938-2243

Grayson County Health Department/Region 2/3
Carolyn Fruthaler, MD
515 North Walnut
Sherman TX 75090
903-893-0131 FAX: 903-892-3776

Greenville-Hunt County Health Department/Region 2/3
Robert F. Deuell, MD, Director
Henry Underwood, DO, Director
2500 Lee Street, Rm. 402
Greenville TX 75401
903-455-1761 FAX: 903-454-1316

Hardin County Health Department/Region 6/4 S
H.A. Hooks, MD, Director
PO Box 820 (77625)
Highway 326 West
Kountze TX 77625
409-246-5188 FAX: 409-246-4373

Harris County Health Department/Region 6/5 S
Thomas Hyslop, MD, MPH, Director
2223 W. Loop South
Houston TX 77027
713-439-6000 FAX: 713-439-6060

Hays County Health Department/Region N
Larry Birdwell, DO, Director
401-A Broadway Drive
San Marcos TX 78666
512-353-4353 FAX: 512-396-4656

Hidalgo County Health Department / Region 11
Mike Keenan, Administrator
Omar Garza, MD, Director
1304 South 25th Street
Edinburg TX 78539-7205
956-383-6221 FAX: 956-383-8864

Houston Health & Human Services Department / Region 6/5 S
Mary desVignes-Kendrick, MD, MPH, Director
8000 North Stadium Drive
Houston TX 77054
713-794-9311 FAX: 713-794-9464 or 713-794-9316

Jackson County Health Department / Region 8
Lanie Benson, MD, Director
411 North Wells, Rm. 102
Edna TX 77957
512-782-5221 FAX: 512-782-7312

Jasper-Newton County Public Health District / Region 4/5 N
Melvin K. Bottorff, MD, FACOG, Director
139 West Lamar Street
Jasper TX 75951
409-384-6829 FAX: 409-384-7861

Live Oak County Health Department/Region 11
Guaracy F. Carvalho, MD, Director
Drawer 670 (78022)
Live Oak County Courthouse
George West TX 78022
512-449-2733 FAX: 512-449-3035

Lubbock City Health Department / Region 1
Doug Goodman, Director
PO Box 2548 (79408)
1902 Texas Avenue
Lubbock TX 79405
806-762-6411 FAX: 806-775-3209

Maverick County Health Department / Region 8
Arturo Batres, MD, Director
490 S. Bibb
Eagle Pass TX 78852
830-773-9438 FAX: 830-773-6450

Marshall-Harrison County Health District/Region 4/5 N
Andrew Gwynne, MD, Director
PO Box 1627 (75670)
98 East Houston Street
Marshall TX 75670
903-938-8338 FAX: 903-938-8330

Medina County Health Department/Region 8
John W. Meyer, MD, Director
3103 Avenue G
Hondo TX 78861
830-741-6191 FAX: 830-741-6149

Midland County Health Department/Region 9/10
Albert J. Esparsen II, Administrator
James M. Humphreys, Jr., MD, Director
PO Box 4905 (79704)
501 Andrews Highway
Midland TX 79701
915-685-7370 FAX: 915-683-4751

Milam County Health Department/Region 7
Sonia Turnbo, Director
E. Douglas Perrin, MD, Director
PO Box 469 (76520)
209 South Houston Street
Cameron TX 76520
817-697-3411 FAX: 817-697-4809

Montgomery County Health Department/Region 6/5 S
UTMB Conroe Clinic
701 East Davis, Suite A
Conroe TX 77301
409-539-7830 FAX: 409-539-7871

Orange County Health Department/Region 6/5
Cathy McClain, Interim Director
UTMB Clinic
PO Box 309 (77630)
2014 North 10th Street
Orange TX 77630
409-883-6119 FAX: 409-883-3147

Paris-Lamar County Health Department/Region 4/5 N
Bill E. Woodruff, MD, Director
PO Box 938 (75460)
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Plainview-Hale County Health District/Region 1
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Port Arthur City Health Department/Region 6/5 S
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San Angelo-Tom Green County Health Department/Region 9/10
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San Antonio Metropolitan Health District/Region 8
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James Mobley, MD, Director
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Scurry County Health Department/Region 2/3
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Smith County Public Health District/Region 4/5 N
D.E. Sciarrini, FAAMA, Director
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Tyler TX 75710
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South Plains Public Health District/Region 1
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Sweetwater-Nolan County Health Department/Region 2/3
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Sweetwater TX 79556
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Texarkana-Bowie County Family Health Center/Region 4/5 N
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Texarkana TX 75501
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Uvalde City-County Health Department/Region 8
Honorable William Mitchell
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Uvalde TX 78801
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Victoria County Health Department/Region 8
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Victoria TX 77902
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Waco-McLennan County Public Health District/Region 7
Janet Emerson, Director
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Wichita Falls-Wichita County Public Health District/Region 2/3
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Williamson County and Cities Public Health District, Region 7
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Georgetown TX 78626
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Wilson County Health Department/Region 8
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Floresville TX 78114
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Wood County Health Department/Region 4/5 N
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Wood County Courthouse
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Quitman TX 75783
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Zavala County Health Department, Region 8
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210-374-3010 FAX: 210-374-3007

1.7 Texas Department of Health Family Planning Agency Funded by Title V, X, XX

1.7.1 Region 1

Coalition of Health Services
John Hicks
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Community Health Center of Lubbock
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Hart ISD
Executive Director
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Lamb Healthcare Center
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Planned Parenthood Association of Lubbock
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Planned Parenthood of Amarillo
Michele Shackelford, CEO
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Amarillo TX 79101-4307
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South Plains Community Action Association
William D. Powell, Executive Director
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Levelland TX 79336-0610
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South Plains Public Health District
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1.7.2 Region 2

Abilene-Taylor County Health Department
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Central Texas Opportunities
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Fisher County Hospital District
Ella Raye Helms, CEO
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Hendrick Provider Network dba Hendrick Family
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Abilene TX 79601
915-670-2214 FAX: 915-670-2293

North Central Texas Medical Foundation
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Sweetwater-Nolan County Health Department
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United Clinics of North Texas
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Wichita Falls City/County Public Health District
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1.7.3 Region 3

Baylor Medical Center of Ellis County
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City of Fort Worth Public Health Department
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Community Health Clinic of Erath
Tammy Cogburn
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Stephenville TX 76401
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Community Health Service Agency
Dan Shepherd, Executive Director
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Denton County Health Department
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Denton TX 76201
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Family Health Care
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Denton TX 76201
940-382-2842 FAX: 940-565-9830

Grayson County Health Department
Carolyn S. Fruthaler, MD, Director
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Sherman TX 75090
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North Texas Home Health Services dba Outreach
Mike Easley, MPA, Director of Family Health
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Austin TX 78758
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Palo Pinto General Hospital District
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Planned Parenthood of Dallas and Northeast Texas
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Dallas TX 75231
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Planned Parenthood of North Texas
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Tarrant County Hospital District
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Fort Worth TX 76104
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UT Southwestern Medical Center
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1.7.4 Region 4

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East Texas Medical Center Regional Healthcare
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Longview Wellness Center
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Smith County Public Health District
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Texarkana-Bowie County Family Health Center
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Texarkana TX 75501
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1.7.5 Region 5

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Jasper/Newton County Public Health District
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Memorial Health System of East Texas
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Lufkin TX 75902
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Orange County Health Department
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1.7.6 Region 6

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City of Houston, Department of Health & Human Services
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Galveston County Health District
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La Marque TX 77568
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Harris County Health Department
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Houston TX 77027
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Montgomery County Health District
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Conroe TX 77301
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Planned Parenthood of Houston and Southeast Texas
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Southeast Texas Family Planning and Cancer Screening
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Houston TX 77074
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Teen Health Clinic/Baylor College of Medicine
Tom Wilson, Director of Sponsored Programs
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Urban Affairs Corporation dba Community Partners
Donna J. Bryant, Executive Director
2815 Reid Street
Houston TX 77026
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UTMB Regional Maternal and Child Health Program
Carolyn Nelson-Becker, Administrative Director
301 University Blvd., Route 0587
Galveston TX 77555-0587
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1.7.7 Region 7

Austin/Travis County Health and Human Services
David Lurie, Director
2100 E. St. Elmo, Building 30E
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Bell County Public Health District
Wayne Farrell, District Director
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Temple TX 76504
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Brazos Valley Community Action Agency
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Bryan TX 77803-4025
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Community Action, Inc. of Hays, Caldwell, and Blanco Counties
Frank Arredondo, Executive Director
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Fayette Memorial Hospital
William F. O"Brien, CEO
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LaGrange TX 78945
409-968-4401 FAX: 409-968-9594

Hays County Health Department
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Hill Country Community Action Association
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Llano Memorial Health Care System
Executive Director
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Llano Memorial Hospital dba Community Clinic
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Llano TX 78643
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People's Community Clinic
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Planned Parenthood of Austin
Glenda Parks, Executive Director
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Planned Parenthood of Central Texas
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1.7.8 Region 8

Atascosa, RHI Health Clinic
Juan H. Flores, CEO
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Barrio Comprehensive Family Health Care System
Carole Chamberlain
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Calhoun County Health Department
Lanie Benson, MD
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Port Lavaca TX 77979
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Community Clinic
Mary M. Mauldin, Executive Director
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Community Council of South Central Texas
Louis R. Ramirez Sr., Executive Director
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Community Council of Southwest Texas
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Cuero Community Hospital
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El Centro Del Barrio
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Ella Austin Health Center
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Gonzales Community Health Agency dba Gonzales
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Hill County Memorial Hospital
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Medina Community Hospital
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Planned Parenthood of San Antonio and South Central Texas
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San Antonio Metropolitan Health District
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South Texas Rural Health Services
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University Health System dba Bexar County Hospital District
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Uvalde Memorial Hospital Healthcare Clinic
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1.7.9 Region 9

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Family Planning of San Angelo
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Midland TX 79701
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San Angelo-Tom Green County Health Department
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1.7.10 Region 10

El Paso City-County Health District
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El Paso County Hospital District dba Thomason
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Planned Parenthood Center of El Paso
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1.7.11 Region 11

Brownsville Community Health Center
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Cameron County Health Department
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San Benito TX 78586-4698
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Community Action Council of South Texas
Francisco G. Zarate, Executive Director
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Gateway Community Health Center
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Laredo Health Department
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Spohn Kleberg Memorial Hospital
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1.8 Program for Amplification for Children of Texas (PACT) Participants

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Abilene TX 79605
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Amarillo Hearing & Speech Center
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Amarillo TX 79106
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Audiology Services
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Fort Worth TX 76132
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Contact Person: Susan M. Howell, M.D.

Audiology & Hearing Aid Services
1703 Tremont
Galveston TX 77550
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Contact Person: Dennis Hatherill, M.S.,Ccc-A

Audiology Associates Of Arlington
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Audio Acoustics Inc. Odessa
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Austin TX 78705
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Austin TX 78756
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3318 Alamed
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Medical Arts Clinic Association
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Family Audiology & Hearing Aid Center
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UT at Dallas Callier Center
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Input Hearing Systems
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Dallas TX 75244
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Contact Person: John R. Gehm, M.S., Ccc-A

Dallas Audiological Services Inc.
7777 Forest Lane, Suite A-107
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214-691-5466
Contact Person: Barbara Murphy,M.S.,Ccc-A

Total Hearing Care Of Dallas
4130 Abrams, Dallas TX 75214
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Physicians Sw Hearing Aid Service
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Speech & Hearing Center Of El Paso
1501 Arizona, Suite 1-D
El Paso TX 79902
915-533-2266
Contact Person: Belinda (Janie) Fanning,M.S.,Ccc-A

El Paso Hearing Aid Center, Inc.
810 N. Kansas
El Paso TX 79902
915-532-9635
Contact Person: Matthew H. Lyon,M.A.,Ccc-A

Midcities Ear, Nose And Throat
451 Westpark Way
Euless TX 76040
817-540-3121
Contact Person: Karen Carr

Child Study Center
1300 West Lancaster
Fort Worth TX 76102
817-336-8611
Contact Person: Lisa Payne,M.S.,Ccc-A

Beltone Hearing Aid Service
216 Ed Carey
Harlingen TX 78550
956-425-4011
Contact Person: James Singleton, M.S.P.A., Ccc-A

Rogers T.H. School
5840 San Felipe
Houston TX 77057
713-783-6220
Contact Person: Michelle C. Hardy, M.S., Ccc-A

N. Harris Co. Coop For Deaf Ed.
14910 Aldine Westfield Rd
Houston TX 77032
713-449-1001
Contact Person: Jean Doconge, M.A., Ccc-A

Hearing Systems Inc.
4654 Hwy 6 N., Suite 201
Houston TX 77084
713-855-8916
Contact Person: David McCarthy, M.A., Ccc-A

Center For Hearing And Speech
3636 W. Dallas
Houston TX 77019
713-523-3633
Contact Person: Carol Cascio, M. Ed., Ccc-A

Texas Children's Hospital
6621 Fannin, Clinical Care Ctr #340
Houston TX 77030
713-770-3249
Contact Person: Betsy Sanford, M.C.D., Ccc-A

Cypress-Fairbanks I.S.D.
10300 Jones Road
Houston TX 77065
713-897-6411
Contact Person: Marilyn Kent, M.S., Ccc-A/Slp

UT Houston Texas Medical School
7400 Fannin, Suite 900
Houston TX 77054
713-792-4752
Contact Person: Nanette Long, M.S., Ccc-A

Better Hearing Services
3433 Prospect
Houston TX 77054
713-520-6470
Contact Person: Jennifer B. Meeks, M.S., Ccc-A

Sound Exchange Hearing Cre Inc.
701 Sharpstown Center
Houston TX 77036
713-271-0977
Contact Person: Terry Griffing

Soundex Hearing Center At TSO
564 Northwest Mall
Houston TX 77092
713-686-1021
Contact Person: Joseph Benevides

Audio Acoustics Inc., Lubbock
3813 22nd Street
Lubbock TX 79410
806-792-0546
Contact Person: Charles Kuratko,M.S.,Ccc-A

Texas Tech Univ. S & H Clinic
PO Box 4266, Tech Station
Lubbock TX 79409
806-742-3908
Contact Person: Tori Gustafon,M.S.,Ccc-A

Ess-Tarrant Co.
617 Seventh St.
Fort Worth TX 76104
817-336-8693
Contact Person: Marsha McClean, M.A., Ccc-A

Meadowbrook Hearing And Speech Cent
6737 Brentwood Stair Rd. #116
Fort Worth TX 76112
817-429-2059
Contact Person: China Wright, M.S.,Ccc-A

Speech & Hearing Serv-Ft Worth ISD
5100 El Campo
Fort Worth TX 76109
817-922-6812
Contact Person: Kathleen E. Chesner, M.S.,Ccc-A

Cooks Ft. Worth Children's M. Center
801 Seventh Ave.
Fort Worth TX 76104
817-885-4063
Contact Person: Cheryl Wolters, M.S.,Ccc-A

Ann E Barsch
510 South Adams Street
Fredericksburg TX 78624
210-997-5006
Contact Person: Ann E. Barsch, M.S.,Ccc-A

UTMB At Galveston Ctr For Audiology
Old John Sealy 7.202. Route E-23
Galveston TX 77550
409-772-2711
Contact Person: Debra Carlson, Ph.D, Ccc-A

ENT Medical Center Of Texas, P. A.
1901 East Northwest Hwy #200
Garland TX 75041
214-271-0516
Contact Person: Penny Scates, M.S., Ccc-

Martin Mcgonagle, M.D.
510 E. Hwy. 377
Granbury TX 76048
817-579-2660
Contact Person: Martin Mcgonagle, M.D.

Valley E.N.T.
1616 S. Carolina
Harlingen TX 78550
956-428-4221
Contact Person: Charles Butler, M.A,Ccc-A

El Mercado E.N.T. & Allergy Clinic
712 N. 77 Sunshine Strip, Suite 21
Harlingen TX 78550
956-428-0757
Contact Person: Lisa Morales

Soundex Hearing Care, Inc.
11127 Fondren
Houston TX 77096
713-981-9951
Contact Person: Joseph Benevides

Irving Hearing Aid Dispensary
800 West Airport Freeway, Suite 118a
Irving TX 75062
214-438-9360
Contact Person: Todd H. Porter, M.A., Ccc-A

Delaney Gordon R., M.D., P. A.
710 Water Street, #404
Kerrville TX 78028
210-896-1433
Contact Person: Debra J. Leon, M.A.,Ccc-A

Hill Country Audiology Service
2368 Junction Hwy
Kerrville TX 78028
210-792-4060
Contact Person: Kenneth B. Aspinall, Ph.D.

Southwestern Health Dev. Corp.
1100 N. 19th St., Suite B-A
Abilene TX 79601
915-670-2134
Contact Person: Susan Atchison

S. Tx. Ent, Head & Neck Specialist
311 Gen. Cavazas Bemd, Ste.K
Kingsville TX 78363
512-595-5438
Contact Person: Michael Jaindl, M.D.

Lunsford Thomas, Md
215 Oak Drive South
Lake Jackson TX 77566
409-299-1520
Contact Person: Kristen Wikert, M.A.,Cfy

Brazosport Ent Clinic, P. A.
201 Oak Drive, S., Suite 207
Lake Jackson TX 77566
409-297-2477
Contact Person: Kristen Wikert, M.A.,Cfy

Laredo Independent School District
1702 Houston
Laredo TX 78040
409-722-8175

Galveston-Brazoria Cooperative
PO Box 799
League City TX 77574
713-338-1664
Contact Person: Hilary L. Reeh, M.A., Ccc-A

Regional Hearing Center
707 Hollybrook Dr., Ste. 402
Longview TX 75601
903-232-3666
Contact Person: Andrea Gohmert, M.S.,Ccc-A

Victory Hearing Aids
3920 West Park Avenue
Orange TX 77630
409-886-2253
Contact Person: Susan P. Cowgill, M.A.,Ccc-A

Loch Hearing Center
3130 Lamar Avenue
Paris TX 75460
903-784-8100
Contact Person: Michael Loch,M.A.,Ccc-A

St. Joseph's Hospital And Health Ctr.
820 Clarksville St.
Paris TX 75461
214-737-3605
Contact Person: Cheryl Watson, Director

David Wilson, M.D.
2404 Yonker
Plainview TX 79072
806-792-0546
Contact Person: Chas Kuratko, M.S., Ccc-A

Quality Hearing Center
2 Richardson Heights No
Richardson TX 75080
214-783-1823
Contact Person: Kate C. Hengsenberg

West Texas Rehab Ctr-San Angelo
3001 S. Jackson
San Angelo TX 76904
915-949-9535
Contact Person: Suzette Olsen,M.S.,Ccc-A

A&B Hearing Aid-San Antonio
6609 Blanco, Suite 115
San Antonio TX 78216
210-342-2299
Contact Person: Terri D. Roberson, M.S.,Ccc-A

Audicles, Inc.
730 N. Main, Suite 215
San Antonio TX 78205
210-227-0259
Contact Person: Jane Watson, M.S.,Ccc-A

Audiphone Co Of South Texas
711 Navarro, Ste 204
San Antonio TX 78205
210-226-2033
Contact Person: James R. Irwin,M.A.,Ccc-A

Harry Jersig Center
411 S. W. 24th Street
San Antonio TX 78285
210-434-6711
Contact Person: Yolanda G. Holguin, M.A.,Ccc-A

Temple Ear, Nose & Throat Center
1809 Sw H.K. Dodgen Loop
Temple TX 76502
817-774-7603
Contact Person: Cathryn Comstock, M.S., Ccc-A

King's Daughters Clinic, P.A.
1905 S.W., H.K.Dodgen Loop
Temple TX 76502
817-778-2123
Contact Person: John Bozeman, M.S., Ccc-A

Temple Memorial Treatment Center
1315 Walnut
Texarkana TX 75501
903-794-2705
Contact Person: Johnathan Miller, M.S., Ccc-A

Rogers, Kathryn M.A., Ccc-A
6 Silverstrand Place
The Woodlands TX 77381
713-367-6143
Contact Person: Kathryn Rogers, M.A. Ccc-A

Vaughn Memorial Speech & Hearing Ctr
904 S. Beckham (PO Box 6400)
Tyler TX 75711
903-531-8190
Contact Person: Laurie Hicks, M.S.,Ccc-A

Victoria Regional Hearing Center
117 Medical Drive
Victoria TX 77904
512-573-4832
Contact Person: George Cire, M.C.D., Ccc-A

Texas School For The Deaf
Attn: Karen Wright, PO Box 3538
Austin TX 78764
512-389-7284
Contact Person: Karen Wright, MA, Ccc-A

UT At Austin Speech & Hearing Ctr.
Communications Bldg. A
Austin TX 78712
512-471-3841
Contact Person: Joan Balash, MA, Ccc-A

Austin Regional Clinic
1301 W 38th Street Ste 401
Austin TX 78705
512-458-4276
Contact Person: Kathryn Jones, MA

San Jacinto Methodist Hospital
4401 Garth Road
Baytown TX 77521
713-420-8676
Contact Person: Karen Landry, MS, Ccc-A

Shaffer Hearing & Speech Center
3330 Fannin
Beaumont TX 77701
409-835-2791
Contact Person: Diane Tunteri, MS, Ccc-A

Lamar University Speech.& Hearing Program
4400 Martin Luther King Parkway
Beaumont TX 77710
409-880-8170
Contact Person: Marshall M. Smith, PhD, Ccc-A

Brenham Clinic Assoc
600 North Park
Brenham TX 77833
409-836-6153
Contact Person: Kathlen B. Thomas, Ccc-A

Brownsville Independent School Dist
2467 Price Rd.
Brownsville TX 78521
210-548-8863
Contact Person: Lisa Gonzales M.S., Cfy

Leipzig, Bruce M.D., P.A.
120 D South Park Drive
Brownwood TX 76801
915-643-5695
Contact Person: Julie Hartig Cormak, MA, Ccc-A

Ess-Brazos Valley Rehab Center
1318 Memorial Drive
Bryan TX 77802
409-776-2872
Contact Person: Amy Velderman, M.S.,Ccc-A

Shea Ear Nose & Throat Clinic
11797 S. Freeway, Suite 132
Burleson TX 76028
817-551-1010
Contact Person: John Cobb, MS, Ccc-A

Allied Health Care, Inc.
1341 W. Mockingbird #215-E
Dallas TX 75247
214-634-7558
Contact Person: David Holmes, Ph.D.,Ccc-A

Easter Seal Society For Children
5701 Maple Avenue
Dallas TX 75235
214-358-5261
Contact Person: Laura Shiplett, MA, Ccc-A

Texoma Otolaryngology Clinic
100 Memorial Dr.
Denison TX 75020
214-463-1130
Contact Person: Kathy Frow, MA, Ccc-A

Denton Hearing Health Care
4309 Mesa Drive, Suite B
Denton TX 76201
817-387-0550
Contact Person: Chris Caudle, MS, Ccc-A

El Paso ENT Association
5959 Gateway West, Suite 160
El Paso TX 79925
915-779-5866
Contact Person Beth A. Longnecker,M.S.P.A,Ccc-A

El Paso Rehabilitation Center
1101 E. Schuster Ave.
El Paso TX 79902
915-544-8484
Contact Person: Janie Gilberti, M.A., Ccc-A

Texas Tech University. S & H Clinic
P. O. Box 4266, Tech Station
Lubbock TX 79409
806-742-3908
Contact Person: Tori Gustafon, M.S.,Ccc-A

Hearing And Speech Care Center
3502 9th Street, Suite 290
Lubbock TX 79415
806-743-1350
Contact Person: Toni Mann, M.S.,Ccc-A

David J. Bailey, M.D.
1000 Ellis Avenue
Lufkin TX 75904
409-639-1350
Contact Person: David J. Bailey, M.D.

Highland Lakes Hearing & Speech. Center
101 Hwy. 281, Suite 310
Marble Falls TX 78654
512-693-7020
Contact Person: Shelley D. Peters, M.S.,Ccc-A

Beltone Hearing Aid Service
PO Box 4378/910 N. Main
McAllen TX 78501
956-686-6881
Contact Person: James Singleton, M.S.P.A., Ccc-A

Family Hearing Aid Center
1401 S. 6th
McAllen TX 78501
956-630-4327
Contact Person: Michael Raff, M.S., Ccc-A

Mesquite Reg Day School Prog Deaf
3811 Richman
Mesquite TX 75150
214-270-8807
Contact Person: Lisa Alt,M.S.,Ccc-A

Audio Acoustics, Inc. Midland
2101 N. Midland Dr. #4
Midland TX 79707
915-689-4327
Contact Person: Orland Purcell, M.S.,Ccc-A

Permian Basin Rehab-Odessa
620 N. Alleghaney
Odessa TX 79761
915-332-8244
Contact Person: Kelly Dyfon, M.A.,Ccc-A

Cepero, Ralph M.D.
603 East Sixth Street
Odessa TX 79761
915-333-8808
Contact Person: Lourdez Zamora-Ferriero,M.A.,Ccc-A

Sunshine Cottage
103 Tuleta Dr.
San Antonio TX 78212
210-824-0579
Contact Person: Jacque Patton, M.S.,Ccc-A

Fernandez Alberto T., M. D.
343 West Houston, #409
San Antonio TX 78205
210-226-9166
Contact Person: Rosanne Beckerwerth, M.S., Ccc-A

Alamo Hearing Aid Services
414 Navarro Ste #1016
San Antonio TX 78205
210-226-5111
Contact Person: Holly K. Spiser-Foley, / M.S., Ccc-A

Komet, Harvey M.D.,Pa.
2829 Babcock Rd. #126
San Antonio TX 78229
210-616-0315
Contact Person: Eugene Paul Guillory, M.A., Ccc-A

Hearing Enhancement Center
1919 Oakwell Farms Pkwy., # 110
San Antonio TX 78218
210-822-7074
Contact Person: Janie F. Gebheim

Hearing And Balance Center
4502 Medical Dr.
San Antonio TX 78229
210-616-2646
Contact Person: John A. Guest

Mclean Audiology & Hearing Aid Center
4402 Vance Jackson # 156
San Antonio TX 78230
210 341-0451
Contact Person: Jodi Mclean

Southwest Texas State University
601 University Drive
San Marcos TX 78666
512-245-8241
Contact Person: Lori Stiritz, M.A., Ccc-A

Collins Emilie S.
1800 N. Travis Ste D
Sherman TX 75090
903-868-2650
Contact Person: Emilie Collins, M.S., Ccc-A

North Central Tx Speech. & Hearing Ctr
2295 N. W. Loop
Stephenville TX 76401
817-968-4174
Contact Person: Susan Gay Dorsett, M.S.,Ccc-A

Scott & White Clinic
2401 S. 31st Street
Temple TX 76508
817-724-2111
Contact Person: Earl W. Stark, Ph.D., Ccc-A

Hillcrest Baptist Medical Center
3000 Herring, PO Box 5100
Waco TX 76708
817-756-8668
Contact Person: Nancy Roche, M.S., Ccc-A

Advance Technology Hearing Aid Ctr
401 Water St.
Waxahachie TX 75165
214-923-2186
Contact Person: Gilbert Ritchey, Ccc-A, M. Ed.

Chester L. Strunk, M.D.
450 Medical Center Blvd. #540
Webster TX 77598
713-338-1423
Contact Person: Stephanie Bryant, M.A., Ccc-A

Wichita Falls Clinic
501 Midwestern Parkway East
Wichita Falls TX 76307
817-766-8779
Contact Person: Karen J. Lavalley, M.A., Ccc-A

Head & Neck Surgical Associates
PO Box 2366
Wichita Falls TX 76307
817-322-6953
Contact: Pam Bender, M.S., Ccc-A

1.9 Texas Commission for the Blind

Abilene District Office
Hines Square
100 Chestnut Street #101
Abilene TX 79605
915-672-1385 FAX: 673-1817

Amarillo District Office
Park West, Building B
7132 I-40 West
Amarillo TX 79106
806-353-9568 FAX: 354-0982

Austin District Office (North)
4800 North Lamar, Suite 100
Austin TX 78756
512-459-2544 FAX: 459-2685

Austin District Office (South)
3001 South Lamar, Suite 200
Austin TX 78704
512-326-1441 FAX: 462-3839

Beaumont District Office
3515 Fannin Street, #103
Beaumont TX 77701
409-838-5201 FAX: 833-7466

Bryan-College Station District Office
Southwest Professional Bldg.
1701 Southwest Parkway, Suite 110
College Station TX 77840
409-696-9610 FAX: 693-4291

Corpus Christi District Office
410 S. Padre Island Drive, Suite 103
Corpus Christi TX 78405
512-289-1128 FAX: 289-0754

Dallas District Office
5925 Maple Avenue, Suite 220
Dallas TX 75235
214-350-0500 FAX: 350-9720

El Paso District Office
7500 Viscount Blvd., Suite 233
El Paso TX 79925
915-779-6385 FAX: 778-2561

Fort Worth District Office
4200 South Freeway #307
Fort Worth TX 76115
817-926-4646 FAX: 926-0049

Texarkana District Office
1423-C College Drive
Texarkana TX 75503
903-793-6779 FAX: 793-4154

Tyler District Office
1121 ESE Loop 323
Woodgate Office Park, Bldg. 1, Suite 106
Tyler TX 75701
903-581-9945 FAX: 581-9944

Victoria District Office
Town Plaza Mall
1502 E. Airline, Suite 13
Victoria TX 77901
512-575-2352 FAX: 576-5712

Galveston District Office
Port Holiday Mall
400 The Strand, Suite 201
Galveston TX 77550
409-762-8631 FAX: 763-1136

Houston District Office
Heights Medical Tower
427 W. 20th Street, Suite 407
Houston TX 77008
713-880-0721 FAX: 880-9209

Laredo District Office
1718 E. Calton, Suite 1
Laredo TX 78041
210-723-2955 FAX: 791-8142

Lubbock District Office
#22 Briercroft Office Pk, Ste 9
Lubbock TX 79412
806-765-7999 FAX: 765-0479

Lufkin District Office
3201 S. Medford, Suite 5
Lufkin TX 75901
409-634-7733 FAX: 634-7731

Odessa District Office
2817 John Ben Sheppard Pky
Building A, Suite 103
Odessa TX 79762-8111
915-368-0881 FAX: 363-8849

Pasadena District Office
3222 Burke Road, Suite 109
Pasadena TX 77504
713-944-9924 FAX: 944-0851

Pharr District Office
1899 N. Cage, Suite E
Pharr TX 78577
210-787-7364 FAX: 702-1596

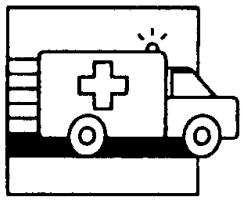
San Angelo District Office
2201 Sherwood Way, Ste 118
San Angelo TX 76901-3030
915-949-4601 FAX: 949-0250

San Antonio District Office
4204 Woodcock Dr., Suite 274
Trinity Building
San Antonio TX 78228
210-732-0751 FAX: 735-7508

Waco District Office
6801 Sanger Ave., Suite 200
Waco TX 76710
817-772-9284 FAX: 751-7522

Wichita Falls District Office
2910 Kemp Blvd., Suite 112
Wichita Falls TX 76308-1040
817-723-2786 FAX: 723-5858

2



Medical Transportation Program (MTP)

Medical Transportation Program (MTP)

The Medical Transportation Program was created in 1975 as a result of a federal court order, Smith vs. Vowell, et. al. MTP is funded with TITLE XIX and state funds and provides Medicaid clients and their attendants nonemergency transportation. When eligible clients and their attendants have no other means of nonemergency transportation, TDH provides the most cost-effective mode of transportation to and from a medical provider that can meet the client's medical needs, including dental services for client under the age of 21.

2.1 MTP Eligibility

Persons who are currently eligible for regular Medicaid benefits and their attendants are eligible to receive services. The client's attending physician must certify the need for an attendant unless the client is a minor, a language or other barrier to communication or mobility exists that requires the assistance of an attendant.

2.2 MTP Requirements

Services are available to eligible clients and their attendants who have no other means of transportation to health care facilities to receive medically necessary Medicaid covered services. In some cases, the client's attending physician will be asked to complete Form 3113, Physician Statement of Need. Form 3113 is required to determine if a particular health-care service is a Medicaid-covered benefit and if the service is medically necessary.

2.3 Contacting MTP

Clients or their advocates should call the statewide MTP toll-free number, **877-633-8747**, to request transportation services. For transportation services within the county, the client or their advocate should call the MTP office at least two workdays before the scheduled appointment. For clients who need to travel outside their county, the client or their advocate should call the MTP office at least five workdays before the scheduled appointment. The following client information must be provided to the intake operator at the time of the call:

- Medicaid Number or Social Security Number
- Name, Address, and Phone number, if available
- Name, Address, and Phone number of health care provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need

2.4 MTP Program Limitations

Clients and their attendants are not eligible to receive medical transportation services under the following circumstances (this is not an all-inclusive list):

- The intended destination is an approved nursing facility, a day activity and health service facility, a personal care home or state institution, or a facility participating in another TITLE XIX program whose rate structure already includes transportation funds.
- If the client has hospital inpatient status.

- The client or another person or entity providing care for the client receives direct payment of worker's compensation benefits, U.S. Department of Veteran Affairs benefits, or other third party resources for transportation to covered services on behalf of the client.
- Clients who are "Limited" to a designated physician and/or pharmacy cannot be transported to another physician or pharmacy unless the designated physician or pharmacy made a referral.
- Transportation of an emergency nature requiring ambulance transportation.
- The client and/or their attendant intentionally, knowingly, or recklessly board a service vehicle carrying an illegal knife, a club, handgun, or other weapon as defined in V.T.C.A. Penal Code Section 46.01, on or about his person.
- Clients age 21 and over and their attendants are not eligible for advance funds, meals and lodging services.
- Clients requiring an attendant by physician orders must have an attendant travel with them at all times until the attending physician notifies the MTP office that an attendant is no longer needed.

3

Texas Health Steps (THSteps)

Texas Health Steps (THSteps)

3.1 THSteps-Medical

The Medicaid service, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), is known in Texas as Texas Health Steps (THSteps).

3.2 Enrollment

To enroll in the Texas Medicaid and THSteps Program, providers must be licensed physicians (MD, DO); or health-care providers of public or private facilities capable of performing the required medical checkup procedures under the direction of a physician, such as:

- Regional and local health departments
- Family planning clinics
- Migrant health clinics
- Community-based hospitals and clinics
- Maternity clinics
- Rural health clinics
- Home health agencies
- School districts
- Family or pediatric nurses

REFER TO:
"Provider Enrollment" on page 2-1 in the Texas Medicaid Provider Procedures Manual *for more information about enrollment procedures.*

Family and pediatric nurse practitioners may enroll independently as THSteps providers. Certified nurse midwives may be enrolled as providers of THSteps medical checkups for newborns, up to two months of age, and adolescent females. Women's health care nurse practitioners may be enrolled as providers of THSteps medical checkups for adolescent females. Adult nurse practitioners may enroll as providers of THSteps checkups for people over 14 years of age.

A registered nurse (RN) or licensed physician assistant (PA) may perform THSteps medical checkups only under the supervision of a physician. The physician ensures that the RN or PA has appropriate training and adequate skills for performing the procedures for which he or she is responsible.

TDH requires that all RNs performing THSteps (EPSDT) medical checkups receive special training in comprehensive pediatric assessment rather than pediatric physical assessment. To be qualified to conduct a THSteps physical examination, RNs must have completed after graduation from nursing school, courses in pediatric assessment which includes the following components: physical assessment, developmental/mental health assessment, nutritional assessment, and anticipatory guidance. This training may be through either credit hours at an accredited college, university, or through approved CEU courses.

If the pediatric course did not include a formal preceptorship (observation of the individual's skills over a period of time), the RN should receive personal supervision by a physician, or family or pediatric nurse practitioners (FNP/PNP) until the physician/FNP/PNP determines the RN to be competent in performing these functions.

Documentation of special training should be included in the employee's personnel file effective January 1, 1999.

The Texas Nurses Association (TNA) offers two approved courses that include:

- Basic Concept in Identifying the Health Needs of Adolescents. This course offers approved CEUs and CPEs through TNA and concentrates on the assessment of the adolescent. The curriculum is composed of state-of-the-art interdisciplinary core content in adolescent health developed by experts in the field. For more information, call a TDH adolescent health coordinator at 512-458-7111, extension 2021. Participants for this course include:
  - Physician assistants
  - Nurse practitioners
  - Registered nurses
  - Social workers
  - Nutritionists
  - Dieticians
- Comprehensive Pediatric Assessment. A clinical preceptorship with a physician or advance practice nurse (APN) is part of this training. Other courses containing the same components are acceptable. Call TNA at 512-452-0645 for more information and enrollment. This course includes an overview of:
  - THSteps
  - Family medical history, pediatric physical assessment
  - Nutritional, developmental, mental assessments
  - Case management
  - Anticipatory guidance

It is recommended that PAs have expertise and/or additional education in the areas of comprehensive pediatric assessment. The course offered by TNA is also available for PAs and provides CEUs for PAs as well as registered nurses. Nurses also may contact TDH at **512-458-7700 ext. 2133** for more information.

Except for federally qualified health centers, currently enrolled Medicaid providers who want to become THSteps providers must enroll separately in the THSteps Medical Checkup Services Program and obtain a separate THSteps (EPSDT) medical checkup provider number. For more information, providers should call NHIC Customer Service at **800-925-9126** or TDH at **512-458-7745**.

THSteps medical checkups may be billed electronically or on a HCFA-1500 or a HCFA-1450 (UB-92) claim form, as appropriate for provider type. Providers may purchase the HCFA-1500 or the UB-92 from the vendor of their choice; NHIC does not supply them. For billing questions call NHIC Customer Service at **800-925-9126**.

3.2.0.1 STAR Program Enrollment

THSteps providers must enroll with each STAR and STAR+PLUS health plan to be reimbursed for services provided to STAR and STAR+PLUS program members.

3.2.0.2 Provider Agreement

REMINDER:
If an enrolled screening provider wants to discontinue participation, written notification must be sent to NHIC so that the provider's name may be removed from the list of enrolled THSteps providers which is given to clients, field staff of TDHS and TDH, or contractors.

The supplemental provider agreement is included in the THSteps enrollment packet.

In the case of a clinic, a physician does not have to be physically present in the clinic at all times during the hours of operation; however, a physician does have to assume responsibility for the clinic's operation.

3.2.1 How the Program Works

THSteps designated staff (TDH, TDHS, or contractor), through outreach and information, encourage clients to use THSteps preventive medical checkup services and the adolescent preventive service visits when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup.

Upon request by the client, TDHS, or TDH (or its contractor) will assist the client with scheduling and transportation.

Providers are encouraged to perform checkups on any client they identify as eligible for medical checkups and adolescent preventive service visits. They are encouraged also to notify the client when he or she is due for the next checkup according to the periodicity schedule.

As part of Texas Welfare Reform (legislated in 1995 by House Bill 1863), TANF clients risk a financial penalty of $25.00 for each child who is not current with THSteps medical checkups and immunizations. Clients do not lose Medicaid eligibility for failure to get medical checkups or immunizations. Medicaid clients who do not receive TANF financial benefits are not subject to penalty.

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file Form HCFA-1500 quickly.

The second source of acceptable verification is a physician's written statement that the checkup has occurred. If the provider chooses to give the client written verification, it must include the child's name, Medicaid ID number, date, and a notation that a complete THSteps checkup has been performed.

To assist providers in furnishing verification, THSteps has developed the THSteps Checkup Verification Form (Form #EPSDT-25, Revised 6/99). Pads of verification forms are available at no cost to the provider. For more information about the THSteps verification forms, call your regional THSteps representative. The representative's name and number are in the "Texas Medicaid Communication Guide" on page A-1 of the *2000 Texas Medicaid Provider Procedures Manual.* Forms may also be ordered by writing to the TDH warehouse.

REFER TO:
"Child Health Clinical Records" on page 7-3 for instructions on how to order.

If neither the first nor the second source of verification is available, a THSteps staff member may contact your office for verification.

The client is periodically eligible for medical checkup services based on the American Academy of Pediatrics (AAP) Periodicity Schedule. A "✓" (checkmark) on the Medicaid Identification Form (3087) indicates eligibility for the service (eye exam, eye glasses, hearing aid, ICF-MR dental, prescriptions, and medical services). A blank space denotes that the client is not periodically eligible for the particular service. Refer to "Vision Care (Optometrists, Opticians)" on page 41-1 of the *2000 Texas Medicaid Provider Procedures Manual*. A THSteps statement under the client's name on the regular Medicaid Identification Form and the STAR Identification Form (3087 STAR) indicates the THSteps services for which the client is currently eligible. Checkups provided when a THSteps statement does not indicate that a medical checkup is due are exceptions to the periodicity schedule. THSteps Adolescent Preventive Visits are not to be billed as an exception to periodicity. Providers who question how current information is on the client's 3087 form are encouraged to call to check the client's eligibility by calling NHIC Customer Service at **800-925-9126** or TexMedNet to check the client's eligibility file. Refer to section 6 of the *2000 Texas Medicaid Provider Procedures Manual*.

REFER TO:
The "Medicaid Identification (Form 3087)" on page 1-19 of the 1999 Texas Medicaid Provider Procedures Manual.

Although the Medicaid Eligibility Verification Form (1027) identifies eligible clients when the Medicaid Identification Form is lost or has not yet been issued, this form does not indicate periodic eligibility for medical checkup services.

A newborn child is eligible for Medicaid for up to one year if all of the following conditions are met: if mother is receiving Medicaid at the time of the child's birth, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant, and the child is living with the mother. **If the newborn has Medicaid coverage, it is not acceptable for a provider to require a deposit for newborn care from a parent/guardian of a newborn.** The child's eligibility ceases if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Assuming the hospital or birthing center notifies TDHS about the newborn child born to a mother eligible for Medicaid, the hospital caseworker, mother, and attending physician (if identified) should receive (a few weeks after birth) an interim notice from TDHS, which includes the child's Medicaid number and effective date of coverage. After the child has been added to the TDHS eligibility file, a Medical Care Identification is issued.

Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn child's Medicaid number.

The Medicaid number on the interim notice (form 1027) may be used to identify newborns eligible for Medicaid for purposes of THSteps medical checkups.

3.3 Medical Home Concept

TDH encourages providers participating in the Texas Medicaid Program to practice the "medical home concept" for clients with Medicaid. To realize the maximum benefit of health care, each individual and family needs to be a participating member of a readily identifiable, community-based medical home. The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership between the individual and family, the health care providers within the medical home, and the extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship. The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community which will assist the family in meeting those needs. When referring for consultation, specialty/hospital services, health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

3.4 THSteps Medical Checkup Facilities

IMPORTANT:
Mobile THSteps units are considered extensions of an office and are not separate entities.

All THSteps medical checkup policies apply to examinations completed in a physician's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a unit is under a physician or clinic name. Mobile units can be a van or any area away from the central office, such as rented space in which THSteps checkups are performed.

For specific information, review the periodicity schedules and narrative explaining the schedules in this section. The physical setting must be appropriate so that all elements of the checkup can be completed.

The checkup includes face-to-face contact with the child's parent or guardian.

3.4.1 Face-to-face Contact

The face-to-face contact facilitates health teaching, discussion of the results, and a referral to a physician for any problems identified during the checkup. The contact also allows the parents or guardians the opportunity to ask questions. It is strongly recommended that all children be referred to a physician or clinic that offers a medical home to the child. If the child who has a primary care physician or a medical home is screened in a mobile unit, the individual performing the medical checkup is asked, as a medical courtesy, to send a copy of the medical checkup information and any findings to the child's primary care physician. All referrals are made through the primary care physician.

A Good Referral Base

To ensure that medical care for children is available and coordinated, all THSteps medical screeners are asked to establish a "good referral base." Providers in areas of the state covered by Medicaid Managed Care should refer to Appendix G in the *1999 Texas Medicaid Provider Procedures Manual* for information about freedom of choice and referrals. The following are some elements of good referral base:

- The individual providing the medical checkup must ask the parents if the child has a private physician or a medical home where the child usually receives medical care (acute care, chronic illness care, etc.).

- Ideally, the provider who performs or supervises medical checkups must offer a medical home to all children receiving a medical checkup under his or her supervision.
- If the medical checkup provider is unable to offer a medical home to the children, the screener must enter into written agreements with providers who are willing to offer medical homes.
- In the case of a provider who has mobile units functioning in different communities, the agreements must be signed in each community so that children are referred to local providers for medical homes.
- If any problem that requires specialized care is identified during the examination, that information must be discussed with the parents, and the referrals made to the child's medical home or an identified provider in the community.
- If the children's medical home is providing THSteps checkups, it is in the children's and family's best interest to encourage that relationship. Mobile providers should advise the family that they have freedom of choice concerning who completes the screens. If the family has a medical home but prefers to be screened by another provider, that provider should send a copy of the THSteps examinations to the primary care provider.
- It is important that follow-up contacts are made to ensure that the children keep appointments when a referral is made. Files should not be closed until the provider knows that the appointment was kept, and a tentative diagnosis for the referral is on file.
- To ensure that a child is referred to a dentist, all providers should have names of one or more dentists to whom the children may be referred. A toll-free number for the most current list is available in each region if, 1) the children have not been seen by a dentist in the past six months, or 2) the screener identifies a need for immediate/emergency dental services.

3.4.2 THSteps Medical Checkups Periodicity Schedule

THSteps adheres to the following Recommendations for Preventive Pediatric Health Care of the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics.

3.5 Recommendations For Preventive Pediatric Health Care

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance and pertinent medical history. Every infant should have a newborn evaluation after birth.

	INFANCY[3]								EARLY CHILDHOOD[3]					MIDDLE CHILDHOOD[3]				ADOLESCENCE[3]										
AGE[4]	NEWBORN[1]	2-4 d[2]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 y	4 y	5 y	6 y	8 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																												
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																												
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•																	
Blood Pressure												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																												
Vision	S	S	S	S	S	S	S	S	S	S	S	O[5]	O	O	S	S	O	S	O	S	S	O	S	S	O	S	S	S
Hearing[6]	S/O	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVORIAL ASSESSMENT[7]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[8]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES: GENERAL[9]																												
Hereditary/Metabolic Screening[10]	←	←	• →					→	←	→			→	←	→			→					→					
Immunization[11]	•			•	•	•			•					•				•										
Lead Screening[12]							•				•																	
Hematocrit or Hemoglobin			←	←	←	←	•											←				•[13]						→
Urinalysis							•							•				←				•[14]						→
PROCEDURES: PATIENTS AT RISK																												
Tuberculin Test[15]								*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening[16]											*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
STD Screening[17]																		*	*	*	*	*	*	*	*	*	*	*
Pelvic Exam[18]																		*	*	*	*	*	*	←	*	*[18]	*	→
ANTICIPATORY GUIDANCE[19]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[20]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
INITIAL DENTAL REFERRAL[21]								•																				

[1]**Breast feeding encouraged and instruction and support offered.**

[2]**For newborns discharged in less than 48 hours after delivery.**

[3]**Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.**

[4]**If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.**

[5]**If the patient is uncooperative, rescreen within six months.**

[6]**Some experts recommend objective appraisal of hearing in the newborn period. The Joint Committee on Infant Hearing has identified patients at significant risk for hearing loss. All children meeting these criteria should be objectively screened. See the Joint Committee on Infant Hearing 1994 Position Statement.**

[7]**By history and appropriate physical examination: if suspicious, by specific objective developmental testing.**

[8]**At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.**

[9]**These may be modified, depending upon entry point into schedule and individual need.**

[10]**Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.**

[11]**Schedule(s) per the Committee on Infectious Diseases, published periodically in *Pediatrics.* Every visit should be an opportunity to update and complete a child's immunizations.**

[12]**Blood lead screen per AAP statement "Lead Poisoning: From Screening to Primary Prevention" (1993)**

[13]**All menstruating adolescents should be screened.**

[14]**Conduct dipstick urinalysis for leukocytes for male and female adolescents.**

[15]**TB testing per AAP statement "Screening for Tuberculosis in Infants and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.**

[16]**Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.**

[17]**All sexually active patients should be screened for sexually transmitted diseases (STDs).**

[18]**All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.**

[19]**Appropriate discussion and counseling should be and integral part of each visit for care.**

[20]**From birth to age 12, refer to AAP's injury prevention program (TIPP) as described in "A Guide to Safety Counseling in Office Practice" (1994)**

[21]**Early initial dental evaluations may be appropriate for some children. Subsequent examinations are prescribed by dentist.**

Key: • = to be performed * = to be performed for patients at risk S = subjective, by history O = objective, by a standard testing method ← → = the range during which a service may be provided, with the dot indicating the preferred age.

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (e.g., inborn errors of metabolism, sickle disease, etc.) is discretionary with the physician.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

3.6 THSteps Medical Checkups Periodicity Schedule

The columns across the top of the periodicity schedule indicating children ages represent the age a client is periodically eligible for the medical checkup. The first column on the left of the chart identifies the procedures that must be performed during the medical checkup. Any time a client enters the program without having received a procedure at the appropriate age, the client must be brought up-to-date as soon as possible. Refer to the footnote instructions at the bottom of the chart.

Age[1]	INPT	INFANCY					EARLY CHILDHOOD				LATE CHILDHOOD							ADOLESCENCE			
	Newborn	WKS	MONTHS								YEARS										
		1-2	2	4	6	9	12	15	18	24	3	4	5	6	8	10	12	14	16	18	20
History																					
Family	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neonatal	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Physical, Mental Health and Developmental History	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical Examination[2]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements																					
Height/Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●											
B/P											●	●	●	●	●	●	●	●	●	●	●
Nutritional Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Mental Health Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screening																					
Vision Screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tuberculin Screening[3]							+	✔	✔	+	+	+	+	+	+	+	+	+	+	+	+
Laboratory Procedures[4]																					
A. Newborn Hereditary/ Metabolic Testing[5]	●	●	✔	✔	✔	✔	✔														
B. Hgb or Hct[6]†					●	✔	●	✔	✔	●	✔	✔	✔	●	✔	✔	●	✔	●	✔	✔
C. Lead Screening[7]†					+	✔	●	✔	+	●	+	+	+	+							
D. Hemoglobin Type[8]	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	●	✔	✔	✔	✔
E. STD Screening[9]																	◆	◆	◆	◆	◆
Immunizations[10]	●	✔	●	●	●	✔	●	✔	✔	✔	✔	●	✔	✔	✔	✔	✔	●	✔	✔	✔
Dental Referral[11]							●	✔	●	●	●	●	●	●	●	●	●	●	●	●	●

● Required.

✔ Required unless already provided on a previous screen at the required age, medically contraindicated or against parental religious beliefs, and documented on the claim form with date of service performed.

\+ If answers on high risk assessment questionnaire note a risk factor, skin testing for TB or lead blood screening are needed. (Refer to footnote 3 for more information about TB Screening.)

† At 12 and 24 months, a hemoglobin is performed as part of the lead screening. The lab request form must be marked for the hemoglobin and lead procedures.

◆ Screen to be performed on sexually active females and males as appropriate.

1 If a child comes under care for the first time at any point on the schedule or if any items are not accomplished at the required age, the schedule is to be brought up to date.

2 A complete physical exam is required at each visit with infant totally unclothed and older children undressed and suitably draped.

3 In areas of low prevalence, administer the questionnaire annually beginning at age 1 year. In areas of high prevalence, administer the skin test at 1 year, once between 4 years through 6 years and once between 11 years through 16 years. Administer the questionnaire annually beginning at age 2 and thereafter at other visits.

4 A federally mandated screening procedure. Clients are not to be referred to a laboratory for completion of the services.

5 Newborn screening [hereditary/metabolic testing (hypothyroidism, PKU, Galactosemia, sickle Hgb, CAH)] is required by Texas law at hospital discharge and between 1 and 2 weeks old. Date of second screen should be documented during first office THSteps medical checkup first year of life. Clients should not be referred to the local health department.

6 Hgb and Hct, done at a WIC clinic or in the office, is acceptable within one month if date and value are documented.

7 Mandatory blood screens at 12 and 24 months. Questionnaire acceptable at other visits. Refer to “Lead Screening Procedures” on page 3-24 in the *Texas Medicaid Service Delivery Guide*.

8 If Hgb type has been performed and results are documented in chart, it does not need to be repeated. Hgb type also is part of the newborn screening.

9 For sexually active or high-risk adolescents, refer to the Adolescent Screening section for information concerning STD.

10 A federally mandated procedure. Clients are not to be referred to the local health department.

11 Dental referrals required for all clients at age 1 and every 6 months thereafter.

12 Counseling/anticipatory guidance are a required integral part of each visit and must be face-to-face.

Dental Sealant													✔	●	✔	✔	●	✔	✔	✔	✔
Health Education[12]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

●	Required.
✔	Required unless already provided on a previous screen at the required age, medically contraindicated or against parental religious beliefs, and documented on the claim form with date of service performed.
+	If answers on high risk assessment questionnaire note a risk factor, skin testing for TB or lead blood screening are needed. (Refer to footnote 3 for more information about TB Screening.)
†	At 12 and 24 months, a hemoglobin is performed as part of the lead screening. The lab request form must be marked for the hemoglobin and lead procedures.
◆	Screen to be performed on sexually active females and males as appropriate.
1	If a child comes under care for the first time at any point on the schedule or if any items are not accomplished at the required age, the schedule is to be brought up to date.
2	A complete physical exam is required at each visit with infant totally unclothed and older children undressed and suitably draped.
3	In areas of low prevalence, administer the questionnaire annually beginning at age 1 year. In areas of high prevalence, administer the skin test at 1 year, once between 4 years through 6 years and once between 11 years through 16 years. Administer the questionnaire annually beginning at age 2 and thereafter at other visits.
4	A federally mandated screening procedure. Clients are not to be referred to a laboratory for completion of the services.
5	Newborn screening [hereditary/metabolic testing (hypothyroidism, PKU, Galactosemia, sickle Hgb, CAH)] is required by Texas law at hospital discharge and between 1 and 2 weeks old. Date of second screen should be documented during first office THSteps medical checkup first year of life. Clients should not be referred to the local health department.
6	Hgb and Hct, done at a WIC clinic or in the office, is acceptable within one month if date and value are documented.
7	Mandatory blood screens at 12 and 24 months. Questionnaire acceptable at other visits. Refer to “Lead Screening Procedures” on page 3-24 in the *Texas Medicaid Service Delivery Guide*.
8	If Hgb type has been performed and results are documented in chart, it does not need to be repeated. Hgb type also is part of the newborn screening.
9	For sexually active or high-risk adolescents, refer to the Adolescent Screening section for information concerning STD.
10	A federally mandated procedure. Clients are not to be referred to the local health department.
11	Dental referrals required for all clients at age 1 and every 6 months thereafter.
12	Counseling/anticipatory guidance are a required integral part of each visit and must be face-to-face.

3.7 THSteps Adolescent Preventive Visit Periodicity Schedule

AGE	11	13	15	17	19
Health Guidance					
Parenting	●	●	●	●	◆
Adolescent Development	●	●	●	●	●
Safety Practices	●	●	●	●	●
Diet Fitness	●	●	●	●	●
Healthy Lifestyles (sexual behavior, smoking, alcohol, drug abuse, or noise exposure)	●	●	●	●	●
Dental Hygiene	●	●	●	●	●
Screening					
Blood pressure[1]	●	●	●	●	●
Cholesterol[2]	■	■	■	■	■
Nutritional Status (BMI)[3]	●	●	●	●	●
Tobacco, alcohol, and drug use	●	●	●	●	●
Unsafe motor vehicle practices	●	●	●	●	●
Firearm safety	●	●	●	●	●
Sexual behavior	●	●	●	●	●
Sexually transmitted diseases (STDs)[4]					
PAP smear (cervical cancer)	★	★	★	★	★
Genital warts	★	★	★	★	★
Cultures:					
Gonorrhea	★	★	★	★	★
Chlamydia	★	★	★	★	★
Blood tests:					
Syphilis	★	★	★	★	★
HIV (screening/testing)	■	■	■	■	■
Depression/suicide risk	●	●	●	●	●
Physical, sexual, or emotional abuse	●	●	●	●	●
Learning problems	●	●	●	●	●
Tuberculosis[5]	■	■	■	■	■
Dental Referral[6]	●	●	●	●	●
Immunizations[7]	✔	✔	✔	✔	✔
Measles, Mumps, and Rubella (MMR)[8]	✔	✔	✔	✔	✔
Diptheria and Tetanus (Td)[9]		✔	✔	✔	

1 Recommendation developed by the National Heart, Lung, and Blood Institute Second Task Force on Blood Pressure Control in Children. In addition to blood pressure measurement, family history should be obtained.
2 Test should be performed if there is a family history of cardiovascular disease before age 55 or parental history of high cholesterol. Physician may choose to perform test if family history is unknown or if adolescent has multiple risk factors for future cardiovascular disease. Recommendation developed by the National Cholesterol Education Program: Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents, 1991.
3 Body Mass Index (BMI) used in assessing eating disorders/obesity. Rating habits/patterns should also be assessed.
4 Tests for STDs should be offered to the adolescent who has engaged in vaginal or anal intercourse, has used injectable drugs, or has history of prior STDs regardless of presence or absence of symptoms. While all adolescents should be screened for the risk of HIV infection, actual testing is voluntary and requires the consent of client. Refer to the *Texas Medicaid Service Delivery Guide*, page 2-40 for more information on HIV testing.
5 Tests should be performed on adolescents who are contacts to a case of active TB, have lived in a homeless shelter, have been incarcerated or live with someone who has been incarcerated, have lived or visit regularly in an area endemic for TB, or currently work in a health care setting; recent immigrant from country with high prevalence of TB; and having associated with someone with HIV infection (May use questionnaire, see tuberculin testing).
6 Dental periodicity is every six months--refer to Dental provider. Evaluate eruption pattern, decay incidence, soft tissue integrity, and mouthguard use in sports.
7 Recommendation developed by the Advisory Committee for Immunization Practices.
8 Immunizations should be provided to adolescents who have only one previous MMR after the age of 1 year.
9 Immunizations should be given 10 years following previous TD booster or at any adolescent visit.
10 Hepatitis B immunization (HBV) should be given to all 11- and 12-year-olds, and teens through age 21.

3.7.0.1 Required Medical Checkup Procedures, Tests, and Standards

The following information lists descriptions and standards for each pediatric assessment and tests that must be performed during a THSteps medical checkup in accordance with the periodicity schedule. The pediatric assessment must be completed by a physician, family or pediatric nurse practitioner, certified nurse midwife (newborn to two months of age and adolescent females), adult nurse practitioner (people over 14 years of age), women's health nurse practitioner (adolescent females), or a registered nurse (RN) or a licensed physician assistant (PA). The RN or PA can perform THSteps medical checkups only under the supervision of a physician. The physician ensures that these providers have appropriate training and adequate skills for performing the procedures for which they are responsible.

3.7.0.2 Child Clinical Health Record

TDH has developed a new child health clinical record that is available for providers. These forms are optional. Copies and ordering instructions are in section 6 of this guide.

3.7.1 History

Physical and Mental Health Development

The initial history must include the family medical history, neonatal history, the child's physical and mental health and developmental history, immunization history, feeding or nutrition problems, and a complete review of body systems. Subsequent histories may be specific for the child's age and past health history.

The history must be completed before the unclothed physical examination and should be obtained from an adult caregiver familiar with the child and the child's past health history.

A complete physical examination is required at each visit with infants totally unclothed, and older children undressed and suitably draped.

The physical examination must include assessment of the following systems:

- Skin
- HEENT
- Dental
- Heart
- Chest/Lungs (includes breast exam for females past menarche)
- Abdomen (including hernia)
- Skeletal
- Neurological (includes evaluation of cerebral, cranial nerve and cerebellar functions, motor and sensory systems and reflexes)
- Genitalia (includes observation for appropriate sexual development and testicular exam for adolescent males)

Adolescent females who are considered sexually active should be encouraged to have a pelvic exam, pap smear, and appropriate screening tests for gonorrhea, chlamydia, syphilis, HIV, bacterial vaginosis, and yeast infection. Law requires HIV, syphilis, and hepatitis B tests be performed during the first prenatal visit and/or time of delivery. Pregnant females are to be informed that a test for HIV will be performed unless the client objects. HIV prevention counseling should be offered before testing a client for HIV. HIV counseling must be offered to any client who tests positive for HIV. A referral to a Medicaid participating physician or family planning clinic should be made.

Adolescent males who are also sexually active should be encouraged to have a STD and HIV screening and should be referred to a participating Medicaid-enrolled physician or family planning clinic.

Pelvic examinations, pap smears, and tests for STDs (except for HIV, syphilis, and hepatitis B tests performed on pregnant females) are not required THSteps medical screening procedures, but are procedures that may be indicated in the Adolescent Preventative Services visits. If the provider offers family planning services within their practice, they may inform the adolescent of the availability of those services.

Individuals suspected of having a genetic disorder should be referred to a genetic services agency for diagnosis and counseling. (Refer to the listing of genetic services agencies in the Genetics section.)

3.7.2 Measurements

The physical examination must include the following measurements:

Height and Weight

- Length, for children approximately 0 - 2 years
- Height, for children approximately 3 - 20 years
- Weight, for children 0 - 20 years

Head Circumference

Frontal-occipital circumference, for children under two years of age.

The above requirements are to be compared to the National Center for Health Statistics growth charts to identify significant deviations from norms.

Blood pressure, for children three years of age and older, using appropriate cuff size.

Age	95% for Age (mm Hg)	Age	95% for Age (mm Hg)
3 - 5 years	116/76	13 - 15 years	136/86
6 - 9 years	122/78	16 - 18 years	142/92
Reference: Report of the Second Task Force on Blood Pressure Control in Children 1987 Peds., Vol. 79, No 1, P1., 1987.			

3.7.3 Nutritional Assessment

The nutritional assessment is to be accomplished in the basic examination through the following methods:

- Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets that are deficient or excessive in one or more food groups
- Determining quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs like WIC)
- A complete physical examination including an oral dental examination, paying special attention to such general features as pallor, apathy, and irritability
- Accurate measurements of height and weight as important indices of nutritional status
- Laboratory screening for anemia (hemoglobin, hematocrit, erythrocyte protoporphyrin [EP]), as indicated.

3.7.4 Developmental Assessment

3.7.4.1 Physicians

Developmental assessment is to be accomplished for each age group based on the physician's personal preference of tests or review of developmental milestones with an adult caregiver familiar with the child as deemed appropriate. It is recommended that at least the following seven elements be included in the assessment:

- Gross motor development, focusing on strength, balance, locomotion

- Fine motor development, focusing on eye-hand coordination (includes vision screening)
- Communication skills/speech-language development, focusing on expression, comprehension, and speech articulation (includes hearing screening)
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children or adolescents, parents, and other adults
- Cognitive skills, focusing on problem solving or reasoning; observation and school progress
- Mental health

Physicians are not required to perform formal developmental screening. It is advised that they consider following the procedures for the "nonphysicians."

3.7.4.2 Requirements for Screening by Nonphysicians

Nonphysicians conducting THSteps checkups on children ages 0 to 6 are required to do a standardized observational developmental screen on each child once between the ages of 9 months and 12 months and once between ages 18 months and 24 months. If, in screening a child 24 months to 6 years, the screener has no record of a standardized observational developmental screen done on the child in the past, the screener should perform a standardized observational developmental screen. Standardized observational screening may be performed at other ages at the discretion of the screener. Standardize observational screening should be performed whenever a parent express concern about the developmental progress of the child.

A standardized parent questionnaire should be used at all other periodic visits up to and including the 6th year. This questionnaire reflects the child's developmental status more accurately than a single observational screen. If parents are unable to read or understand the questionnaire, the provider should use the parent questionnaire in an interview format. If the child fails the parent questionnaire, follow the instructions of the tool concerning either observation testing or referral.

Children seven and older should be screened by observation, history of school progress and neurological assessment.

Choice and Use of Tools. A standardized tool is one that has been extensively evaluated through screening thousands of children and comparing the screen outcome of each individual child with the outcome of an in-depth developmental evaluation on that child.

If the screening tool specifies that training is required to use the tool, the screener must complete this training.

The Denver II is one recommended observation screening tool. The Pre-Denver Questionnaire is one recommended standardized parent questionnaire. Testing materials can be ordered from:

Denver Developmental Materials
PO Box 6919
Denver, CO 80206-0919
800-419-4729 or 303-355-4729

Other acceptable standardized parent questionnaires are discussed on page 68, Nelsons Textbook of Pediatrics, 15th edition, Richard E. Behrman, Editor, 1996.

Referrals. Criteria for referral (for an in-depth developmental evaluation) is defined by the designers of the tool and should be clearly understood and followed by the screener.

Referrals for in-depth evaluation of development must be made to an ECI program (ages 0 through 3 years) for suspected delay, as required by state law. The provider may also refer to a pediatrician with skill in developmental assessment, or the school district (ages 3 years and older).

Referral for in-depth evaluation of development should be provided whenever a parent expresses concern about their child's development regardless of scoring on observational screening or the parent questionnaire.

3.7.5 Mental Health

The mental health assessment is part of every comprehensive THSteps checkup. The purpose of the screen is to identify problems in any of six domains: feelings, behavior, social interactions, thinking, physical problems and other problems which may include substance abuse. Screening may reveal several minor problems or one or more significant problems that warrant referral for/or provision of evaluation and, if indicated, treatment. Optional age specific interview tools, parent questionnaires, and more extensive guidelines are included in "THSteps Guidelines and Forms" on page 7-1.

3.7.6 Sensory Screening

3.7.6.1 Vision Screening

Children of all ages must have their vision checked as part of the THSteps screen. Vision screening in young children requires patience and skill. Testing must be appropriate to the age, ability, and cooperation level of the child. See the AAP periodicity schedule for those visits that require objective testing, such as an eye chart.

3.7.7 THSteps Vision Screening

THSteps Vision Screening

Recommended Tests	Referral Criteria	Comments
Initial test at birth		
Check for "red reflex"		Note history for high-risk conditions such as congenital infections (rubella, herpes, etc.) or family history of vision or eye problems
Children 0 - 2 years of age		
Observation and history from a caregiver Check for "red reflex" Pupils equally react to light Screening for heterophoria with the corneal light reflex and cover test for children over 6 months	Cover test: Any eye movement	Note history for high-risk conditions such as congenital infections (rubella, herpes, etc.) or family history of vision or eye problems
Children 3-4 years of age		
Tumbling E or H:O:T:V: test or equivalent Screening through the 20/20 line Screening for heterophoria with the corneal light reflex and cover test or Random Dot E	Child should read more than half of the 20/40 line or four out of six H:O:T:V: symbols Refer children with two-line difference between the two eyes Cover test: Any eye movement Less than 4 of 6 correct	If a 3-year-old is unable to cooperate, document and complete the test as described for 0-2 years
Children ages five and up		
Letter chart or Tumbling E chart Cover test or Random Dot E	Refer if unable to read majority of 20/30 line or four out of six H:O:T:V: symbols. Any eye movement Less than 4 of 6 correct	

Vision screening supplies may be ordered from the following:

Snellen Letter "Tumbling E" Wall Charts Prevent Blindness Texas 3211 West Dallas Houston TX 77019 713-526-2559	**Vision Testing Equipment Good-lite Company 1540 Hannah Ave Forest Part, IL 60130 708-366-3860**

Vision charts may also be purchased through:

School Health
865 Muirfield Drive
Hanover Park IL 60103
800-323-1300

3.7.8 Hearing Screening

Children birth to three years must have hearing screened by observation and history obtained from a responsible adult familiar with the child. The Hearing Checklist for Parents in this section should be used because the results are more valid than can be obtained through gross screening. English and Spanish versions are available. It is recommended that infants who are high risk for hearing impairment be referred to a Medicaid enrolled physician who renders audiology services for formal screening, preferably before discharge from the newborn nursery but no later than three months of age. Electrophysiological testing of newborns can be effectively performed as early as 12 hours after birth. Behavioral testing of infant's hearing can be done when the baby's developmental age reaches six months.

It is recommended that children be assessed with a puretone audiometric hearing screen (1000, 2000, and 4000 Hz) at the ages noted on the AAP periodicity schedule. A subjective hearing evaluation should include patient history and observation of the child/adolescent for ability to answer questions and follow directions. Children who do not respond to a 25 dB tone at any frequency should be referred for a diagnostic hearing evaluation. Some children will receive audiometric testing as part of a school screening program. If known, these results are acceptable and need not be duplicated.

At the initial test at birth, the physician should:

- Check for obvious physical abnormalities.
- Note indicators associated with possible hearing loss and refer for formal testing.
- Supply hearing checklist for parents, and instruct on its use. This should be discussed at the first visit.

At birth to three years:

- Observation and history from a responsible adult familiar with the child. (Use Hearing Checklist for Parents.)
- Refer high-risk children to a physician who renders audiology services.
- Behavioral testing can be done once the child has a behavioral age of six months, or by a pediatric audiologist as early as a few hours after birth.

At four years of age and over:

- Puretone audiometric hearing screen is required. (Testing through the school is acceptable.)
- Observation and history.
- Refer children with risk factors to a physician who renders audiology services.

Children identified during the screen as needing a diagnostic hearing evaluation or other hearing services including hearing aids are to be referred to an approved hearing service provider. TDH provides payment for services rendered by these providers to children

eligible for Medicaid and under age 21 years. TDH provides payment to these same providers for hearing services provided to low-income children who are not eligible for Medicaid. Services for children whose family income is under 150 percent of the federal poverty income limit (whether or not the child is eligible for Medicaid) are administered through the Program for Amplification for Children of Texas (PACT).

Questions on the program may be directed by telephone or in writing to:

Program for Amplification for Children of Texas
Bureau of Children's Health
TDH
1100 West 49th Street
Austin TX 78756-3199
512-458-7724

3.7.8.1 Hearing Screening Questions

Questions concerning Otoacoustic Emissions (OAE) or Auditory Brainstem Response (ABR) are referred to the following contacts:

Billing, Codes, and Price Information:	NHIC Customer Service	800-925-9126
Guidelines and Policy:	TDH	512-458-7111
Testing Procedures:	TDH	512-458-7726

The following are the CPT codes for OAE and ABR:

Procedure Code	Description
5-92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
5-92588	Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
5-92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system

3.7.9 Tuberculosis Testing

The periodicity schedule for tuberculin tests is in accordance with federal Centers for Disease Control (CDC) guidelines. THSteps requires a form of TB screening at every visit as noted on the periodicity schedule.

A questionnaire has been developed to determine if the child or adolescent is at high-risk for tuberculosis and needs Mantoux screening. This questionnaire and guideline material was developed by the TB Elimination Division at the TDH and follows current CDC guidelines.

In accordance with the recommendations of the TDH of Health TB Elimination Division, the THSteps division now requires the following:

The provider will determine whether his or her service area is a high-prevalence area for TB. This is determined by the local health authority.

In areas of low prevalence the provider will administer the TB Risk Questionnaire beginning at age 1 year and annually thereafter. TB skin testing should be done if the questionnaire indicates a risk factor, or if the provider determines that a skin test is appropriate.

In areas of high prevalence, TB skin testing should be administered at age 1, once between 4 and 6, and once between ages 11 and 16. If the client refuses the skin test or the child is uncooperative, administer the questionnaire. The questionnaire should be administered annually beginning at age two years and thereafter. In those age ranges where a skin test is recommended, the provider should administer the skin test at one of these ages and the

IMPORTANT:
"Live virus vaccines can interfere with response to a tuberculin test. TB Testing, if otherwise indicated, can be done either on the same day that the live virus vaccines are administered or 4 to 6 weeks later." MMWR Vol. 43 #RR 1 p. 15.

questionnaire at the other annual check ups. The TB skin test should also be administered at these ages if a risk factor is indicated or if the provider determines a skin test is appropriate.

Children whose medical checkup is an exception to periodicity due to placement in foster care should be skin tested at that visit.

Any newly identified positive reactions should be evaluated by a screening provider or referred for evaluation. Report any suspected cases or diagnosed cases of tuberculosis to the local health department.

Tuberculin tests are to be performed in the provider's office or clinic. The materials (PPD-Mantoux antigen and syringe) are distributed free of charge to the provider upon request by the local or regional health departments. The cost of administering the test is included in the screening fee. If a follow-up screening visit is required to check a **presumptive positive reaction,** the provider may bill the follow-up medical screening visit fee of $6. Diagnosis and treatment are provided as a Medicaid office visit. **TINE testing is not supplied by TDH and should not be used.**

Refer to "Guidelines: Tuberculosis Skin Testing (2 pages)" on page 7-58 and "Tuberculosis Testing" on page 3-19 of this guide.

3.7.10 THSteps Medical Checkup Laboratory Procedures

3.7.10.1 Screening Services

The following laboratory screening procedures are a **required** component of the THSteps medical checkup and are to be provided in accordance with the age and frequency specified on the Medical screening periodicity schedule.

IMPORTANT: **All required laboratory work is to be performed by the Bureau of Laboratories, TDH.** TDH makes these services available free of charge to all enrolled THSteps medical checkup providers. THSteps laboratory specimens submitted to TDH must include the client's Medicaid number on a THSteps Laboratory Request (Form NBS-3, G-401, G-72, G-73, G-74). If a number is not currently available, but is pending (i.e., a newborn; a newly certified client verified by a Form 1027 as eligible for Medicaid), write PENDING in the Medicaid number space. Laboratory specimens received at TDH which do not have a Medicaid number or the word PENDING written in the 9-digit space for the Medicaid number will not be analyzed. Claims submitted by a provider or an outside lab on or after the same date of service as a THSteps medical checkup will be denied and are subject to retrospective review.

3.7.10.2 THSteps Laboratory Services

All THSteps laboratory testing is done at TDH. Newborn Screen, Medical Checkup, and Adolescent Preventive Service Visit laboratory test specimens are collected by the medical provider and mailed to TDH. Test results that are considered of a "critical" nature are telephoned to the provider by laboratory staff. TDH mails test results to the provider.

IMPORTANT:
These services and supplies are limited to THSteps screening laboratory services provided in the course of a medical screen to THSteps clients. Unauthorized use of services and supplies is in violation of federal regulations.

The following are medical checkup laboratory tests available from the TDH Clinical Chemistry Laboratory and procedures employed:	
Test	Total Hemoglobin
Normal Result	11-16 g/dL
Procedure	Cyanmethemoglobin
Test	Hemoglobinopathy
Normal Result	A,A (Homozygous Adult)
Procedure	Isoelectric Focusing
Test	RPR Card Test
Normal Result	NR (Non-Reactive)
Procedure	18 mm RPR Circle Card Test
Test	Lead Screen
Normal Result	Pb <10 ug/dL
Procedure	Atomic Absorption (Graphite Furnace)
	Erythrocyte Protoporphyrin Procedure
	(EP-Extraction, Piomelli) performed on lead screens
	≥ to 25 ug/dL
	Normal result for EP: < 35 ug/dL

The $48.19 reimbursement for the complete medical screen covers obtaining the blood specimen for testing. There is no additional reimbursement for specimen collection.

Providers are reminded that the THSteps screen no longer requires that patients have rubella testing done.

RPR tests are now optional and are to be completed at the provider's discretion on high-risk children and adults.

THSteps providers are reminded that specimens submitted to the TDH laboratory **MUST** have the patient's Medicaid number or the word PENDING on the laboratory request form. Specimens without this information will be rejected for testing.

3.7.10.3 Send Comments

If you have complaints or compliments about THSteps specimen collection supplies, please send a brief letter or FAX. Supplies are continually evaluated and comments from supply users are solicited. Documented comments are used to support or change an item in a state contract.

Laboratory Services
Bureau of Laboratories
TDH
1100 West 49th Street
Austin TX 78756-3199
Fax: 512-458-7672

3.7.10.4 Newborn Testing

Articles 4447e and 4447e-1, Texas Revised Civil Statutes, require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin, and congenital adrenal hyperplasia on all newborns. This testing is the responsibility of any provider attending the birth of a baby (for example, physicians, CNMs). **All infants must be tested a second time at one to two weeks of age.** If there is any doubt that a child under 12 months of age was properly tested,

the provider should submit the blood sample on the appropriate TDH Form NBS-3 to the Newborn Screening Laboratory at TDH.

The provider should note the following:

- Complete information, instructions (including blood sample collection procedures), and newborn screening forms are available from the address below:

Bureau of Laboratories
TDH
1100 West 49th Street
Austin TX 78756-3199
512-458-7331 (no collect calls)

- Results are mailed to the address of the provider on Form NBS-3.
- Laboratory recommendations for necessary follow-up procedures are included with the report.
- TDH calls the provider in cases of significant abnormality.

3.7.10.5 Hemoglobin or Hematocrit

Hemoglobin or hematocrit levels are required as a screening procedure to indicate anemia resulting from poor diet or diseases. The required minimum frequency for hemoglobin or hematocrit testing is at ages 6 months, 12 months, 24 months, 6 years, 12 years and 16 years. At 12 and 24 months, hemoglobin should be quantitated in conjunction with the lead screen. The laboratory request form must be marked for both hemoglobin and lead.

The provider should note the following:

- The TDH laboratory uses the cyanmethemoglobin method to measure hemoglobin only.
- The TDH laboratory calls the provider when analysis indicates a hemoglobin result of 7 g/dL or less.

3.7.10.6 Lead Screening

Childhood Lead Poisoning Notice

Additional regional contacts and assessment tools are available to aid in the awareness and detection of childhood lead poisoning. Each Texas Department of Health (TDH) regional office now has a designated regional lead poisoning prevention contact person. Providers may call this person if a child is lost to follow-up or if an environmental investigation is needed. For general lead prevention inquiries, call 512-458-7111, ext. 6441.

The M-100 (Lead Assessment Interview Tool) has been revised. Providers no longer have to write a separate letter as a request for an environmental investigation. Providers can now request an environmental investigation by:

- Completing the revised Lead Assessment Interview Tool
- Signing the bottom of it, and
- Sending it to the health department responsible for environmental investigations in their community

Children who qualify for an environmental investigation are those with confirmed lead levels of 20 µg/dL and greater, or those who have had a confirmed lead level between 15-19 µg/dL for three to four months. TDH regional outreach workers now have a script written in English and Spanish, which is geared toward getting a child back in for follow-up lead testing.

Providers may order lead poisoning prevention brochures (in English or Spanish) in addition to the "Get the Lead Out -- Detection and Management of Childhood Lead Poisoning: Guidelines for Physicians and Health Care Providers" by sending a fax on letterhead to the attention of the TDH warehouse manager. Be sure to include the catalog number, title of the brochure, quantity, your phone number, and the address and name of the person to which the materials should be sent. Also note that all newly enrolled THSteps

providers will get the manual with the initial shipment of lab supplies. THSteps providers will continue to be contacted either by phone and/or mail by the Childhood Lead Poisoning Prevention Program (CLPPP) coordinator for follow-up regarding children with blood lead levels of 20 µg/dL or greater.

The following tables list helpful telephone numbers, regional lead contact persons, and informational material available to order:

Telephone Number Description	Telephone Number
Childhood Lead Poisoning Prevention Program (CLPPP)	**512-458-7111, ext. 6441**
Epidemiology (to report a high blood lead level)	**800-588-1248**
Warehouse to order materials (also can be ordered in small quantities from CLPPP) or fax requests for forms, brochures	**512-458-7761 or 512-458-7413 fax**
Environmental Health - TDH Austin TX	**512-834-6612**

Region No(s).	Region Contact	Telephone Number
1	Ben Gordon	**806-744-3577**
2 & 3	Georgette Boozer	**817-264-4251**
4 & 5	Barbara Brandon	**903-595-3585**
5 & 6	Peggy Gulledge	**713-767-3150**
7	Phyllis Stone	**254-778-6744, ext. 2306**
8	Sheryl Shudde	**210-949-2000, ext. 206**
9	Joyce Casey	**915-683-9492**
10	Julie Flores	**915-774-6200**
11	Russell Armstrong	**956-423-0130**

Lead Poisoning Materials Available to Order	
Catalog No.	**Title of Information**
1-301	Get the Lead Out: Intervention (English)
1-301A	Get the Lead Out: Intervention (Spanish)
1-302	Get the Lead Out: Prevention (English)
1-302A	Get the Lead Out: Prevention (Spanish)
1-303	Get the Lead Out: Renovation (English)
1-303A	Get the Lead Out: Renovation (Spanish)
1-306	Get the Lead Out: Detection and Management of Childhood Lead Poisoning; Guidelines for Physicians and Health Care Providers (Winter 1996)
13-32	Get the Lead Out with Good Nutrition (English/Spanish)
M-100	Lead Assessment Interview Tool
1-26	What Parents Need to Know About Lead Poisoning (English)
1-26A	What Parents Need to Know About Lead Poisoning (Spanish)
1-305	Which of These is Poisonous to Your Child (Poster)

Blood specimens for lead screening are evaluated by direct measurement of lead concentration in the sample. As of October 23, 1992, acceptable limits for lead concentration were

lowered from < 25 ug/dL to < 10 ug/dL with a lead concentration of 10 ug/dL or higher are now being reflected as above the acceptable limit.

The provider should note the following for the lead screen analysis:

- The (capillary) lead screen analysis is subject to a false positive result from skin lead contamination during collection. A soap and water wash of the puncture site and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.
- The EP and the blood lead screening results should be compared to assess the relative risk of lead poisoning. An elevated EP result (≥ 35 ug/dL) indicates high correlation with physiological exposure to lead when compared to a blood lead concentration ≥ 25 ug/dL. A normal EP result (< 35 ug/dL) for a blood lead concentration ≥ 25 ug/dL, however, is a strong indication of sample contamination.
- The EP analysis is not performed on blood lead elevations between 10 ug/dL and 24 ug/dL since the EP analysis cannot reliably indicate physiological status of lead exposure at the low abnormal concentration.

3.7.10.7 Guidelines for Follow-up of Elevated Blood Leads

This table presents interpretation of blood lead test results and follow-up activities.

Advised Protocols for follow-up of elevated blood lead in children under six years of age.

Blood lead ≤ 9 ug/dL (Class I):

A child in Class I is not considered lead poisoned.

Blood lead 10-14 ug/dL (Class IIA):

a. The parent should be informed (face to face, by telephone, or by letter) that they should make an appointment for the child in 3-4 months.

b. Test every 3-4 months until two consecutive tests are < 10 ug/dL or three consecutive tests are < 15 ug/dL.

Blood lead 15-19 ug/dL (Class IIB):

a. Confirm capillary results with venous blood specimen. Skin contaminants can cause falsely elevated results. The inter-assay variability of the blood lead assay is + or -3 ug/dL. Repeat venous testing should be done within a month if possible as levels can rise acutely.

b. As (b) above. Tracking should be employed to ensure follow-up.

c. Supply parent with information concerning lead poisoning prevention, proper nutrition (adequate iron, calcium, zinc, and protein), appropriate hygiene practices (thorough damp mopping and wet wiping, frequent handwashing, etc.), and controlling pica.

d. Conduct an environmental assessment INTERVIEW (TDH form #M-100). This form can be obtained from TDH, Literature and Forms Division, 1100 West 49th Street, Austin, Texas 78756-3199, or from the TDH Web site, **www.tdh.state.tx.us**. This is the first step in identifying the source of lead.

e. If two consecutive follow-up tests 3-4 months apart remain in this range, the parents have been thoroughly counseled and the INTERVIEW has been completed, a HOME VISIT may be indicated to assess the environment for lead contaminants. The local or regional health department may assist you in home investigations. Please first contact your local health department. If a representative from that office is unable to conduct the home visit or there is no health department in your town, you may contact the regional TDH office. If staff is unavailable for a home visit, the regional health department may refer a request directly for environmental investigation.

f. An ENVIRONMENTAL INVESTIGATION is needed only when the INTERVIEW and HOME VISIT have failed to identify the source of lead. This investigation can be requested from the local or regional health department. If the child spends most of his/her time with a babysitter, at a daycare center, school, or other home, this location must be investigated also. (Detection and Management of Childhood Lead Poisoning, TDH, Winter 1996)

Blood lead 20-44 ug/dL (Class III):

a. Steps (a)-(f) above. The repeat test (venous sample) should be done within one week. If confirmed to be = to or > 20 ug/dL:

g. Conduct (or refer for) a complete medical evaluation: physical exam, including, but not limited to, growth assessment, blood pressure, hearing acuity, peripheral nerve function; developmental assessment; and laboratory assessment. Check for iron deficiency as it often co-exists with lead poisoning and can exacerbate lead toxicity. Serum iron, iron-binding capacity, and ferritin should be measured. Serum ferritin = to or < 12 ug/dL indicates iron deficiency. A blood lead > 40 ug/dL should prompt a serum creatinine to assess renal function.

h. Some physicians advise oral medications if blood lead remains in this range. Call the Childhood Lead Poisoning Prevention Program at TDH at **512-458-7111, ext. 6441**, for the name of a physician or institution willing to advise on treatment. It is inadvisable to treat medically without identifying and removing the source of contamination.

i. Abatement or containment of lead source.

Blood lead 45-69 ug/dL (Class IV):

(a)-(i) as above. Begin medical treatment and environmental assessment and remediation within 48 hours. Pharmacologic treatment is indicated and should be conducted under the guidance of a physician experienced in the treatment of lead poisoning.

Blood lead ≥ 70 ug/dL (Class V):

Considered a medical emergency. Medical treatment and environmental assessment/remediation must begin immediately.

3.7.10.8 Hemoglobin Type

If the hemoglobin type has been done, including as a part of newborn screening, and results are documented on the chart, it does not need to be repeated. Hemoglobin type by electrophoresis is required once during the adolescent years, but may also be done at the discretion of the provider as appropriate for age and population groups. For instance, certain children need this procedure to screen for sickle cell disease or trait.

The provider must note the following when checking for hemoglobinopathies:

- TDH uses isoelectric focusing for initial screening. Confirmatory analysis (for HbS, HbC, HbE, HbO, etc.) is made using isoelectric focusing and/or citrate agar electrophoresis as necessary.

- Laboratory reports list the hemoglobin types detected. In cases where definitive results are not possible, appropriate explanations are provided. Notes are also entered if results are clinically significant.
- Quantitative figures are reported only in the following instances:
  - HbF present in a patient over one year of age
  - Elevated A2 detected (possible thalassemia)

3.7.10.9 Rapid Plasma Reagin (RPR) Card Test

A Rapid Plasma Reagin (RPR) Card Test is no longer a required screening procedure on every client age 12 and older who is provided a THSteps medical screen. However, any client having one or more of the following risk factors should be screened for STD:

- History of injecting drug use (IDU)
- History of STD
- Having unprotected vaginal, anal, or oral sex, or having a sex partner with a history of intravenous drug abuse or an STD

3.7.10.10 Urinalysis

Urinalysis (e.g., dipstick) is performed at the discretion of the provider. Providers must purchase their own materials. This cost is included in the fee for screening service.

3.7.10.11 Laboratory Supplies

Upon request, TDH provides the items listed below that are associated with blood specimen collection. All newly enrolled screening providers automatically receive a start-up package of forms and supplies.

- 2 mL vacuum tube (with anticoagulant) for venipuncture
- 1 mL capillary blood collector (with anticoagulant)
- 7 mL vacuum tube (without anticoagulant) for venipuncture (required for RPR)
- 22 gauge x 1-1/2 inch vacuum needle
- Lancets (long point)
- Laboratory Form G-401
- Mailing container with postage paid label (single tube or multiple tube)
- "Laboratory Screening Services" handbook

IMPORTANT:
Limited number of holders (small and large) are supplied on request.

All reorder requests for forms and supplies should be made on TDH Form G-399 (refer to the "THSteps Laboratory Supplies Order Form" in the *Texas Medicaid Service Delivery Guide)*; submit forms to the following address:

Bureau of Laboratories
TDH
1100 West 49th Street
Austin TX 78756-3199
512-458-7661

Supply requests can be faxed to the TDH laboratory at **512-458-7672**. Providers are requested not to order more than a three-month supply as most supplies have expiration dates and must be rotated frequently for efficient usage. To reduce waste in ordering, TDH monitors supply requests according to the number of specimens submitted by the provider. Keep unused tubes with anticoagulant in an airtight self-closing plastic bag to prevent moisture from reaching the anticoagulant.

Providers should make a request on the laboratory form if an extreme health problem exists and telephone results are needed quickly. Reports of a critical nature are routinely given to the provider by telephone (e.g., hemoglobin equal to or below 7 g/dL, lead $\geq$ 40 ug/dL).

THSteps services provided in a private laboratory cannot be reimbursed.

All required laboratory work is to be performed by the TDH. Necessary testing, forms, instructions, and supplies are made available free of charge to the provider.

3.7.11 Follow-Up Care Guidelines Summary Table

Laboratory Results									Interpretation	Refer for Follow-up Care	Genetics Counseling
RPR Card			Hgb	Hgb Type		E.P.		Lead			
NR	R	Titer	g/dL	A: A	Other	<35 ug/dL	ug/dL	ug/dL			
X									Serological signs of syphilis not present.	No	
	X								Possible indication of syphilis. Further testing necessary.	Yes	
	X	1:1 etc.							Indication of degree of reactivity of laboratory result. 1:1, 1:2, 1:4, etc. Confirmed by TP-PA or FTA.	Yes	
								<10	Normal	No	
								10 - 14	Retest periodically. Refer to “Guidelines for Follow-up of Elevated Blood Leads” on page 3-25.	Yes	
								15 - 19	Retest periodically. Refer to “Guidelines for Follow-up of Elevated Blood Leads” on page 3-25.	Yes	
							35 - 249	20 - 69	Treatment needed. Refer to “Guidelines for Follow-up of Elevated Blood Leads” on page 3-25.	Yes	
							≥250	≥70	Emergency care needed. Refer to “Guidelines for Follow-up of Elevated Blood Leads” on page 3-25.	Yes	
				X					Normal adult hemoglobin present.	No	
					A, F				Probably normal on patients younger than 12 months. Percentage of F given if over 12 months. Should be retested after first birthday.	No	
					A, S				Probably sickle trait condition (carrier of sickle cell). Check patient history.	No	X
					A, F, S				Usually occurs in infants. Probably will result in sickle trait when F declines to normal adult levels.	No	X
					A,C				Probably C-trait condition.	No	X
				Probably A,D or A,G					Either D-trait or G-trait condition, but could be other Hgb having similar properties on electrophoresis.	No	X
				A, Other					Probable unknown trait condition. (Contact TDH for availability of complete structural analysis through reference laboratory.)	No	X
				S,S					Indicative of sickle cell disease. Total hemoglobin usually low (7 - 8 g/dL)	Yes	X
				S,F					Probably sickle cell disease. Should be checked for HPFH. If F < 20%, possible S-beta thalassemia.	Yes	X
				S,C					Probably indicative of hemoglobin S-C disease.	Yes	X
				C,C					Probably homozygous C disease.	Yes	X
				S,A					Probable S-beta thalassemia.	Yes	X
			<11.0						Probably anemic. Evaluate according to severity.	Yes	

3.7.11.1 Laboratory Screening Services Handbook

TDH has a Laboratory Screening Services Handbook available on request to any THSteps medical screening provider. The handbook provides supplementary information on required laboratory test procedures, interpretation of laboratory test results, guidelines and criteria for referral and follow-up, and instructions on specimen collection and handling. The handbook can be obtained by writing to the following address:

Bureau of Laboratories
Clinical Chemistry Branch
TDH
1100 West 49th
Austin TX 78756-3199

3.7.11.2 Laboratory Collection

All required laboratory specimens are to be submitted to TDH for testing. Necessary forms, instructions, and supplies are available through TDH (refer to section 6 for copies of forms). (Hemoglobin/hematocrit can be performed in the physician's office. There is no additional reimbursement for this service.)

Providers are to follow the procedures and guidelines listed below when collecting samples for laboratory screening. Universal precautions should be observed:

- Specimens submitted to TDH for blood lead tests, total hemoglobin tests, and hemoglobin type tests are to consist of whole anticoagulated blood (EDTA) collected in tubes (one tube per patient). Specimens for RPR Card Test must be clotted blood or serum collected in a plain tube (red stopper). Specimen collection materials are supplied by TDH.

IMPORTANT:
A venipuncture specimen is required for RPR test for syphilis.

Venipuncture. Venipuncture technique is strongly recommended over the capillary method. A capillary specimen is subject to false values due to dilution, hemolysis, or lead contamination.

Specimens collected in vacuum tubes with anticoagulant must be mixed vigorously to ensure proper mixing.

Capillary (Finger/Heel Punctures). In response to questions concerning the use of capillary punctures to obtain blood specimens in children under one year of age, the following quotation has been taken from the October 1991, Centers for Disease Control and Prevention (CDC) publication, "Preventing Lead Poisoning in Young Children," page 82, Item C:

Puncturing of the fingers of infants less than 1 year of age is not recommended. Puncturing of the heel is more suitable for these children (NCCLS, 1986).

Except for an RPR, a capillary specimen is acceptable. If the child is less than one year old, a heelstick may be performed. If capillary specimen collection is used, the following information should be noted:

Clotted blood or an insufficient quantity of blood are the two primary reasons specimens are unsatisfactory for TDH Laboratory testing.

About 40 clotted specimens are detected in every 1000 THSteps fingerstick specimens received by the laboratory. Unfortunately, these specimens cannot be accurately tested for lead or hemoglobin. If less than 500uL, there may not be sufficient sample to perform these tests. In either situation, the laboratory sends a report with an explanation as to why a specimen was unsatisfactory for testing.

1) **Slow Blood Flow -** Clotting can occur before blood comes in contact with anticoagulant. For fingersticks, strike the fingertip slightly off center with a LONG point lancet and hold the finger at a level below the patient's heart so that gravity can assist in speeding specimen collection.

2) **Inadequate Mixing -** Blood does not mix well in capillary blood collection devices. SHAKE VIGOROUSLY. None of the THSteps laboratory procedures are adversely affected by shaking whole blood.

3) **Over-filled Vial -** Fill vial ONLY half full (500uL). A vial filled more than half-full has a lower ratio of anticoagulant to blood which may cause blood to clot. Heat during shipment can cause sample expansion thereby dislodging the collection cap. Additionally, it is very difficult to mix a full tube.

4) **Date of Expiration -** Vials that are beyond their expiration date have less effective anticoagulant. Retain the expiration date provided with capillary blood collection devices and replace these as the date approaches.

5) **Contamination**

- Wash the patient's hand or foot with soap and water to remove surface contamination before antiseptic cleaning. (Alcohol cleansing alone is not sufficient to remove lead from the skin.)
- The person obtaining the specimen should assure noncontamination with their collection techniques (i.e., wearing gloves).
- Discard dropped collection vials.
- Blood should be collected through the capillary top of the container or dropped into the tube if it does not have such a top.
- Do not use venipuncture tubes to collect capillary samples. (There is excessive anticoagulant in the venipuncture tubes for the smaller samples.) The result is a diluted specimen that is unsuitable for testing.

All THSteps Specimens

- Tightly secure all capillary blood collector caps before placing into mailer. All venipuncture tubes must be packed carefully to avoid breakage in shipment.
- Mail specimens on the day of collection if possible. Do not hold for mailing longer than three days. Specimens that cannot be mailed immediately should be refrigerated. **Do not freeze**. **Do not stack**.
- Specimens for lead screening analysis should be placed in the dark immediately following collection, (for example, in a closed mailer). Falsely elevated EP values can occur from excessive exposure to light.

Newborn. For newborn screening, follow the instructions on the blood collection form.

3.7.11.3 Submission of Specimens

Specimens submitted to TDH for routine testing must be accompanied by a THSteps Laboratory Request Form (G-401) which is supplied by TDH (example in section 6*)*. Each form must contain all the requested information legibly displayed through all copies of the form.

IMPORTANT:
The space labeled "clinic code" is optional for provider use to designate their suboffices. Any alphanumeric entries in this space will appear on the patient's test results report.

Copy one (white) must be sent to the TDH laboratory and copy two (yellow) must be retained by the provider for their records at the time of collection. **Each specimen tube submitted must have the first and last name of the patient as it appears on Form G-401 (including "Jr.," "III," etc.).** Enter the code letter for suboffices using the same provider number in the "Clinic Code" space.

TDH Laboratory is licensed under Clinical Laboratory Improvement Amendments (CLIA) 1988 and therefore must meet certain legal requirements of this law. A recent licensure clarification requires that a patient's specimen must have the patient's name permanently attached to the specimen tube. The accompanying test request form must have the same name, **exactly** as it appears on the tube (including "Jr.," "III," etc.).

This requirement means that for a THSteps specimen, laboratory tests may be performed **only** if the specimen tube is labeled and the patient's name on the tube exactly matches the test request form.

A suggestion for fingerstick collection tubes, i.e., capillectors: Write the patient's name on adhesive tape, small address label medical tape, masking tape or on the tube (indelible marker only), exactly as it appears on the test request form, so that the patient's name is permanently attached to the tube.

3.7.12 Reports of Laboratory Testing

Laboratory reports are received by the provider approximately seven to 10 days after the specimens are mailed to TDH. Laboratory processing takes approximately three working days plus transit time to and from the TDH Laboratory in Austin. Inquiries concerning reports not received after 14 days may be made by writing or calling the TDH Laboratory, **512-458-7578**; collect calls cannot be accepted. (Call **512-458-7331** for information about newborn testing.)

3.7.13 Lead Screening Procedures

It is mandatory that children be tested in accordance with the periodicity schedule and that children at risk for high-dose lead exposure be screened more frequently than required. Refer to the "THSteps Medical Checkups Periodicity Schedule" on page 3-11.

The THSteps Program requires that children be screened for lead poisoning at ages 6, 12, 18, and 24 months, and annually thereafter until age 6 years. Results of THSteps lead screening show that elevated lead levels are found in all geographic areas of Texas and in all age groups.

IMPORTANT:
The abbreviated questionnaire may be used for children with previously recorded normal blood lead level.

Lead screening involves actual blood lead analysis or completion of a parent questionnaire (with appropriate action taken depending on the answers). Blood lead analyses are mandatory at ages 12 and 24 months. At other THSteps periodic visits (6 months, 18 months, 3, 4, 5, and 6 years) the parent questionnaire may be administered. The parent questionnaire is found in this volume. If (at any age) the parent answers "yes" or "I don't know" to any of the questions, a blood lead analysis is indicated. Providers may copy the questionnaire from section 6 of this guide or order copies (10 copy limit) from TDH at **512-458-7745**.

If the provider does not use the parent questionnaire, he or she must continue to have blood lead testing performed at 6, 12, 18 and 24 months, and annually thereafter until age 6 years.

Providers may obtain more information concerning the medical and environmental management of lead poisoned children from the Texas Childhood Lead Poisoning Prevention Program by calling **512-458-7700 ext. 6441**.

3.7.14 Follow-up Physician Care Guidelines

Refer to the updated summary table on interpretation of laboratory test results and guidelines for follow-up for children with elevated blood lead levels on page 3-27. Note that providers are responsible for initiating environmental assessments (refer to the Environmental Investigations Section on page 3-31) for children with blood lead levels of greater than or equal to 15 ug/dL. Providers are responsible for confirming capillary blood lead results with a venous blood lead measurement on children with blood lead levels of 15 ug/dL or above.

If the initial lead screen is elevated, recalling children for the purpose of taking a venous blood sample can be billed as a follow-up medical screening visit and the specimen can be submitted to the TDH Clinical Chemistry Laboratory in the same manner as for all other THSteps laboratory blood specimens.

3.7.14.1 Follow-up of Elevated Blood Lead Screening

The Bureau of Children's Health (BCH) of TDH has established a follow-up program to track the care provided to children who have had a blood lead of 20 ug/dL or above detected during a THSteps screen. If a child screened has a blood lead of $\geq$ 40 ug/dL, the provider will receive a telephone call from the laboratory and the BCH office with an offer of technical assistance. Physicians in various parts of the state have offered to be available to advise on treatment procedures for these children. This information will be offered when BCH staff calls.

For blood leads of $\geq$ 20 ug/dL, a letter is sent requesting the provider to forward results of subsequent lead testing to BCH staff. This letter is sent to the provider approximately six weeks or less after BCH receives the laboratory results. A letter is also sent to the parent/

guardian regarding the high lead level. The parent/guardian is encouraged to contact the health care provider to schedule another appointment.

3.7.14.2 Client Lead Poisoning Prevention Counseling

As part of the anticipatory guidance given during a client's medical screening visit, all families must be given detailed lead poisoning prevention counseling and childhood lead prevention material.

The following is an excerpt on anticipatory guidance from the Centers for Disease Control's October 1991 statement on "Preventing Lead Poisoning in Young Children."

Anticipatory guidance means "teaching parents about major sources of lead and how to prevent poisoning" and "tailoring guidance to likely hazards in the community."

Pediatric health care providers consider education to be an integral part of well-child care. Along with educating parents about nutrition and developmental stages, providers should discuss the potential hazards of lead. They should focus on the major preventable sources of high-dose lead poisoning - lead-based paint and take-home exposures from parents' occupations and hobbies. Parents should be told of the potential dangers of peeling lead-based paint, the potential hazards of removing peeling lead-based paint, the potential hazards of renovating older homes, and the need for good work practices if their occupations or hobbies expose them to lead. Other education should be tailored to potential exposures in the community. Where water lead levels are a concern, parents should be advised to use only fully flushed water (that is, water that has not been standing in pipes for a prolonged time) from the cold-water tap for drinking, cooking, or preparing infant formula.

3.7.15 Environmental Investigations

Providers should first contact their local health department to request assistance with environmental assessments for children with venous lead levels of 20 ug/dL or greater, or when two consecutive tests, three to four months apart, remain in the 15 ug/dL to 19 ug/dL level. Staff from the local health department can conduct a home visit and formal environmental investigation, if necessary. If the local health department is unable to assist, then contact the closest TDH Public Health Regional (PHR) Office.

3.7.15.1 Geographic Areas at High-Risk for Lead Contamination

TDH is committed to performing "targeted" client outreach/informing in the THSteps Medical Checkup Program directed at THSteps clients living in geographic areas/sites determined by official federal/state agencies to be high-risk for lead contamination. Although TDHS routinely informs clients about medical screening, additional efforts will be made by TDH to encourage clients living in designated high-risk areas to obtain medical screening services, including blood lead level testing. You will be notified about these special project sites as they become known, by TDH and/or through the *Texas Medicaid Bulletin*. THSteps clients targeted for medical screening in these project sites are considered at risk for elevated blood lead levels and are to always have lead testing performed as part of the THSteps Medical checkup regardless of age.

3.7.16 Immunizations

Children must be immunized during medical checkups according to the Recommended Childhood Immunization Schedule for the United States. See "Immunizations" on page 5-1. The checkup provider is responsible for the administration of immunizations and must not refer children to local health departments. TDH requires that immunizations be administered unless medically contraindicated or against parental religious beliefs.

A $5.00 administration fee is paid for immunizations given during a THSteps checkup or as part of a follow-up. THSteps providers should bill for each vaccine separately. If administering a combined vaccine such as DTaP (diphtheria, tetanus, and pertussis vaccines), do not bill separately for each antigen.

The TDH Immunization Division provides vaccines for children who receive services under THSteps. Vaccine Information Statements are required by federal mandate, to inform parents and vaccine recipients of the risk and benefits of the vaccine they are about to

receive. Not only is it important to provide these before a vaccine is administered, but also it is very important that providers use the most current forms available. For more information regarding immunizations or literature and forms, call the TDH Immunization Division at 800-252-9152.

3.7.17 Health Education/Anticipatory Guidance

IMPORTANT:
Refer to Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, National M & CH Clearinghouse 8201 Greensboro Drive, Ste. 600, McLean, VA, 22102 or Guidelines for Health Supervision II from the American Academy of Pediatrics Publication Department, PO Box 927, 141 Northwest Point Blvd., Elkgrove Village, IL 60009-0927.

Health education is a federally mandated component of the medical screen and includes anticipatory guidance. Health education and counseling face to face with parent(s) or guardian(s) and children is required and designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention. Written material may also be given, but will not replace face to face counseling.

The medical screening must include age and developmentally appropriate health education, anticipatory guidance, and counseling on the following:

- Developmental expectations (per age of child)
- Dental health
- Sleep
- Feeding and nutrition
- Breast or testicle self-examination
- Elimination
- Lead poisoning risks
- Healthy lifestyle/practices
- Accident and disease prevention

3.7.18 Medical/Other Service Referrals

3.7.18.1 Referrals for Medicaid Covered Services

When a screening provider who performs the checkup determines that a referral for diagnosis and treatment is necessary for a condition found during screening, the referral should be made to the provider who is qualified to perform diagnosis and treatment services. If the provider performing the medical checkup can provide treatment for the condition identified, a separate claim may be submitted on the same day as the checkup with an appropriate office visit for the diagnosis and treatment of the identified problem.

The newest periodicity schedule, published by the American Academy of Pediatrics (AAP), on page 39-16, identifies the components that must be performed during a THSteps medical checkup based on the age of the child. In order to give providers time to make a smooth transition to the new schedule, the NHIC system will accept billing of THSteps checkups each year from ages 2-6 years and 11-20 years, or will accept billing for the older version of the periodicity schedule, and for the adolescent preventative service visits, printed on page 39-17. If a provider believes a child of 24 months up to 21 years of age needs two comprehensive care checkups in a given year, the second visit must be billed as an exception to periodicity.

All of the checkups listed on the periodicity schedules, beginning on page 39-16, have been developed under the leadership of the AAP. The newest version, on page 39-16, differs in that the annual examinations for adolescents have been included in this single periodicity schedule to emphasize the AAP recommendation that comprehensive checkups be performed annually. The AAP continues to emphasize the importance of separate counseling and anticipatory guidance for the child and the accompanying parent/guardian during the adolescent years. The provider is encouraged to emphasize the educational components based on risk assessment.

Effort should be made to maintain continuity of care. Providers in areas of the state covered by Medicaid Managed Care should refer to "TDH - Administered Medicaid Services" on page G-1 of the *2000 Texas Medicaid Provider Procedures Manual* for more information on referrals.

3.7.18.2 Referrals for THSteps-Comprehensive Care Program (THSteps-CCP) Services

CCP benefits are either federal Medicaid allowable services currently not covered under the Texas Medicaid Program (e.g., orthotics, private duty nursing, etc.) or expanded coverage of current services which have limitations.

3.7.18.3 Referrals for Family Planning and Genetic Services

For people eligible for Medicaid needing genetic services or family planning services, a referral should be made. Information on Medicaid covered genetic services is available in the Genetics section of the *Texas Medicaid Provider Procedures Manual* and information on Medicaid covered family planning services is available in the Family Planning Agency section of the *Texas Medicaid Provider Procedures Manual*. If the screening provider also provides family planning, the provider may inform the client of these services.

REFER TO:
"THSteps-Comprehensive Care Program (CCP)" on page 39-25 of the 2000 Texas Medicaid Provider Procedures Manual for CCP service requirements (client eligibility, prior authorization, and provider participation).

3.7.19 Dental Referrals

3.7.19.1 Routine Dental Referrals

Routine dental examination referrals are to be made on all children at age one and every six months thereafter. Children under one are not eligible for routine dental examinations. However, children under one year of age should be referred when a medical screening identifies the medical necessity for dental services.

3.7.19.2 Clients up to the age of 21 may also self-refer for dental care.

3.7.19.3 Emergency Dental Referrals

If a medical screening provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all THSteps clients eligible for Medicaid and up to 21 years of age.

In cases of emergency or nonemergency dental services, clients have freedom of choice in selecting a dental provider who is participating in the THSteps Dental Program.

3.8 THSteps Adolescent Preventive Service Visits

3.8.1 Client Eligibility

The client must be THSteps-eligible and be 11, 13, 15, 17, or 19 years of age at the time of the service delivery.

NOTE:
Information noted in "THSteps Adolescent Preventive Service Visits" on page 3-33 is for providers still using the TDH schedule on or after September 1, 1999.

3.8.2 Benefits

For providers still using the TDH schedule, adolescent preventive service screening visits are covered under the THSteps Medical Screening Program. An "Adolescent Preventive Visit" is not considered an exception to Periodicity. The adolescent preventive screening visits are in addition to the regular THSteps periodic medical checkups.

The protocol for performing these preventive screening visits includes comprehensive health guidance for adolescents and their parents, screening for specific conditions relatively common to adolescents, and the use of immunizations to prevent selected infectious diseases. Visits for clients ages 11, 13, 15, 17, and 19 years old are to include the services as outlined in the periodicity schedule. (There will be no change in the screening protocol procedures for the other age groups.)

3.8.3 Provider Participation/Reimbursement

THSteps medical screening providers will be reimbursed for provision of services.

Payment for the adolescent preventive visit will be $48.19 with the addition of $5 for each immunization administered during the screening visit. The $48.19 fee includes payment for administering TB tests and collecting the specimens for all required laboratory work. Payment for a follow-up screening visit remains at $6 plus $5 for each immunization administered during the adolescent preventive health visit. Combined antigen vaccines are reimbursed as one dose. Like other preventive screening visits, free vaccine and free TB test supplies will be made available to providers from TDH's local health departments/districts and regional offices. Providers in areas of the state covered by Medicaid Managed Care should refer to Appendix G of the *Texas Medicaid Provider Procedures Manual*.

3.8.4 Adolescent Preventive Visit Periodicity Schedule

Refer to "THSteps Adolescent Preventive Visit Periodicity Schedule" on page 3-13. The columns across the top of the Periodicity Schedule by Age represent the age brackets during which a client is periodically eligible for the adolescent preventive visit. The column down the left of the chart lists the procedures that must be performed during the adolescent preventive visit. Any time a client enters the program or has not received a procedure at the appropriate age, the client should be brought up to date as soon as possible. Refer to the footnote instructions at the bottom of the chart.

3.8.5 Teen Confidentiality Issues

THSteps has developed a summary of Texas laws addressing these legal issues for all THSteps providers:

- Consent for the medical and mental health care of a minor
- Information discovered during an adolescent visit may be kept confidential

Letters have been developed to be sent to clients and teens in both English and Spanish. These letters explain what to expect in a THSteps Adolescent checkup or Adolescent Preventive visit, and encourage open discussion about the management of confidential information.

This information is helpful in understanding the rights of minors, parents, other guardians, and the provider. Actual mailing dates of the summary and letters will be announced in a future *Texas Medicaid Bulletin*. Direct questions about adolescent health care to Florastine Mack, R.N., Adolescent Health Coordinator: **512-458-7111 Ext. 2021**.

3.8.6 Medical History

Information on current health status, past medical history, and family history should be obtained and/or updated at the time of the preventive health screening visit. The adolescent and the parent should preferably be interviewed separately.

3.8.7 Health Guidance

3.8.7.1 Parenting

Parents or adult caregivers should be provided information about:

- Normal adolescent development (physical, sexual, and emotional development)
- Signs/symptoms of disease and emotional distress
- Parenting behaviors that promote healthy adolescent adjustment
- Why parents should discuss health-related behaviors, plan family activities, and act as role models for health-related behaviors
- Methods for helping their child avoid potentially harmful behaviors, such as:
    - Monitoring and managing the adolescent's use of motor vehicles, especially for new drivers

- Making weapons inaccessible to adolescents. Ensure that adolescents follow weapon safety procedures if weapons are available.
- Removal of weapons and potentially lethal medications from the homes of adolescents who have suicidal intent
- Monitoring social/recreational activities for use of tobacco, alcohol, and drugs, and for sexual behavior
- Providing a specific health guidance to teen parents

With approval of the American Medical Association, we have been granted permission to reproduce The Parent Package, which has been designed to help health care providers share important information about adolescence with parents. The package is available in English and Spanish. Request a copy by calling the Child Health and Safety Division at **512-458-7111, ext. 2027**.

3.8.7.2 Adolescent Development

Give adolescents health guidance to:

- Promote a better understanding of their physical growth, psychosocial and psychosexual development
- The importance of becoming involved in decisions on their health care

3.8.7.3 Safety Practices

Give adolescents health guidance on injury prevention:

- Avoid the use of alcohol or other substances while using motor or recreational vehicles, or where impaired judgment may lead to injury
- Use safety devices, including seat belts, motorcycle and bicycle helmets, and appropriate athletic protective devices
- Resolve interpersonal conflicts without violence
- Avoid the use of weapons and/or promote weapon safety
- Obtain appropriate physical conditioning before exercise

3.8.7.4 Diet and Fitness

Give adolescents health guidance on:

- Benefits of a healthy diet
- Ways to achieve a healthy diet
- Safe weight management
- Benefits of exercise
- Safe exercise on a regular basis
- Benefits of adequate rest

3.8.7.5 Healthy Lifestyles

Give adolescents health guidance on:

- Avoidance of tobacco, alcohol, high noise exposure, other abusable substances, and anabolic steroids
- Abstention from sexual intercourse as the most effective way to prevent pregnancy and sexually transmissible diseases (STDs), including HIV infection
- Transmission of the HIV infection, the dangers of the disease, and the fact that latex condoms are effective in reducing the risk of STDs, including HIV infection
- Reinforcement of responsible sexual behavior for adolescents who are not currently sexually active and for those who are using birth control and condoms appropriately

- Need to protect themselves and their partners from pregnancy, STDs, including HIV infection, and sexual exploitation

3.8.7.6 Dental Guidance

Give adolescents dental health guidance on:

- Reinforce daily hygiene practices
- Regular dental visits
- Use of smokeless tobacco

3.8.8 Adolescent Screening

Hypertension (Blood Pressure) - Screening and follow-up services are to be performed following the protocol developed by the National Heart, Lung, and Blood Institute Second Task Force on Blood Pressure Control in Children.

- Adolescents with either systolic or diastolic pressures at or above the 90th percentile for gender and age should have blood pressure (BP) measurements repeated at three different times within one month, under similar physical conditions, to confirm baseline values.
- Adolescents with baseline BP values greater than the 95th percentile for gender and age should have a complete biomedical evaluation to establish treatment options. Adolescents with BP values between the 90th and 95th percentiles should be assessed for obesity and have their blood pressure monitored every six months.

3.8.8.1 Hyperlipidemia Screening

Hyperlipidemia (Non-Fasting Blood Cholesterol and Fasting Lipoprotein Analysis) Screening and follow-up services are to be provided in accordance with the following protocol developed by the Expert Panel on Blood Cholesterol Levels in Children/Adolescents:

- Adolescents that have a parent with a serum cholesterol level greater than 240 mg/dL and adolescents who are over 19 years of age should be screened for total blood cholesterol level (nonfasting) at least once.
- Adolescents that have a parent or grandparent with angina pectoris, coronary artery disease, documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death at 55 or younger should be screened with a fasting lipoprotein analysis because a high proportion of these children will have some lipoprotein abnormality.
- Treatment options are based on the average of two assessments of low-density lipoprotein cholesterol (LDL). Values below 110 mg/dL are acceptable; between 110 and 120 mg/dL are considered borderline and lipoprotein status should be reevaluated in one year. Adolescents with values of 130 mg/dL or greater should be referred for further medical evaluation and treatment.

3.8.8.2 Eating Disorders and Obesity

Measure:

- Weight
- Height

Ask about:

- Body Image and Dieting Patterns
- Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found: weight loss greater than 10 percent of previous weight, recurrent dieting when not overweight, use of self-induced emesis, laxatives, starvation, or diuretics to lose weight, distorted body image, or body mass index (weight/height) below the fifth percentile

- Adolescents with a body mass index (BMI) equal to or greater than the 95th percentile for age and gender are overweight and should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease.
- Adolescents with a BMI between the 85th and 94th percentile are at risk for becoming overweight. A dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease should be performed on these youth if:
    - Their BMI has increased by two or more units during the previous 12 months
    - There is a family history of premature heart disease, obesity, hypertension, or diabetes mellitus
    - They express concern about their weight
    - They have elevated serum cholesterol levels or blood pressure

If this assessment is negative, these adolescents should be provided general dietary and exercise counseling and should be monitored annually.

3.8.8.3 Tobacco Use

Ask about use of cigarettes and smokeless tobacco:

- Adolescents who use tobacco products should be assessed further to determine their patterns of use
- A cessation plan should be provided for adolescents who use tobacco products

3.8.8.4 Alcohol and Drug Use

Ask about the use of:

- Alcohol and other drugs
    - Other substance use (marijuana, cocaine, etc.)
    - Over-the-counter or prescription drugs (for nonmedical purposes), including anabolic steroids
- Adolescents who report any use of alcohol or other drugs or inappropriate use of medicines during the past year should be assessed further regarding family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation about use, use of other drugs and the adequacy of physical, psychosocial, and school functioning
- Adolescents whose substance use endangers their health should receive counseling and mental health treatment, as appropriate
- Adolescents who use anabolic steroids should be counseled to stop, and counseled about the danger of sharing needles
- The use of urine toxicology for the routine screening of adolescents is not recommended
- Adolescents who use alcohol or other drugs should also be asked about their sexual behavior and their use of tobacco products

Sexual Behavior/Sexually Transmitted Diseases (STDs)

Ask about:

- Involvement in sexual behaviors (that could result in unintended pregnancy and/or STDs, including HIV infection)
    - Adolescents who are sexually active should be asked about their use and motivation to use condoms and contraceptive methods, their sexual orientation, the number of sexual partners they have had, if they have exchanged sex for money or drugs, and their history of prior pregnancy or STDs

- Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on how to reduce this risk
- Adolescents who are sexually active should also be asked about their use of tobacco products, alcohol, and other drugs

STD Screening Procedures for Sexually Active Adolescents

- **Gonorrhea/Chlamydia** Adolescents will be tested for gonorrhea and chlamydia using the most appropriate testing methodology.
- **Genital Warts** Evaluation for human papilloma virus by visual inspection (males and females) and by Pap smear.
- **Syphilis** Individuals at risk are to receive a test (Rapid Plasma Reagin (RPR) Card Test) for syphilis if they have lived in an area endemic for syphilis, have had STDs, have exchanged sex for drugs or money, or have had unprotected vaginal, anal, or oral sex
- **HIV Infection** Adolescents at risk for HIV infection should be offered confidential HIV counseling and testing with the enzyme immunoassay (ELISA) and confirmatory test. Law requires an HIV, syphilis, and hepatitis B test be performed during the first prenatal visit and/or at the time of delivery. Pregnant females are to be informed that an HIV test will be performed unless a client objects.

IMPORTANT:
If a presumptive test for STDs is positive, tests to make a definitive diagnosis should be performed, a treatment plan instituted according to treatment guidelines developed by the Centers for Disease Control (CDC), and the use of condoms encouraged.

- **Risk status** includes having used injectable drugs, having had STD infections, having lived in an area with a high prevalence of STDs or HIV infection, having had vaginal, anal, or oral sex, having exchanged sex for drugs or money, or having had a sexual partner who is at risk for HIV infection (i.e., injecting drug use).
  - HIV testing should be performed only after informed consent is obtained from the adolescent, except in the case of a pregnant female, when HIV testing is to be performed unless the female objects.
  - HIV testing should be performed only in conjunction with both pre- and post-test counseling.
  - The frequency of screening for HIV infection should be determined by the risk-factors of the individual.

3.8.8.5 Cervical Cancer/Pap Smear

Female adolescents who are sexually active or any female who is 18 years old or older is to be screened for cervical cancer by use of a Pap smear. (Refer to the section on cervical cancer screening-pap smear.)

Adolescents with a positive Pap smear should be referred for further diagnostic assessment and management.

See page 3-40 for cervical cancer screening procedures.

3.8.8.6 Depression/Suicide Risk

Ask about:

- Behavior/emotions that indicate recurrent or severe depression or suicide risk.
  - Screening for depression or suicidal risk should be performed on adolescents who exhibit cumulative risk as determined by declining school grades, chronic melancholy, family dysfunction, homelessness, anxiety regarding homosexual orientation, physical or sexual abuse, alcohol or other drug use, previous suicide attempt, and suicidal inclination or plans.
  - If suicidal risk is suspected, adolescents should be evaluated immediately and referred to a psychiatrist or other mental health professional, or else should be hospitalized for immediate evaluation.
  - Nonsuicidal adolescents with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

3.8.8.7 Physical, Sexual, or Emotional Abuse

Ask about:

- History of emotional, physical, and sexual abuse.
  - If abuse is suspected, adolescents should be assessed to determine the circumstances surrounding the abuse and the presence of physical, emotional, and psychosocial consequences, including involvement in health risk behaviors.
  - Health providers should be aware of local laws about the reporting of abuse to appropriate state officials, in addition to ethical and legal issues regarding how to protect the confidentiality of the adolescent patient.
  - Adolescents who report emotional or psychosocial sequelae should be referred to a psychiatrist or other mental health professional for evaluation and treatment.

3.8.8.8 Learning Problems

Ask about:

- Learning or school problems.
  - Adolescents with a history of truancy, repeated absences, or poor or declining performance should be assessed for the presence of conditions that could interfere with school success. These include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, alcoholic or other drug abuse.
  - This assessment and the subsequent management plan should be coordinated with school personnel and with the adolescent's parents or caregivers.
  - Noise exposure (music, motorcycles, cars, etc.)

3.8.9 Tuberculosis Testing

The periodicity schedule for tuberculin tests is in accordance with federal Centers for Disease Control (CDC) guidelines. THSteps requires a form of TB screening at every visit as noted on the adolescent preventive screen periodicity schedule.

A questionnaire has been developed to determine if the child or adolescent is at high-risk for tuberculosis and needs Mantoux screening. This questionnaire and guideline material was developed by the TB Elimination Division at the TDH and follows current CDC guidelines.

The provider will determine whether his or her service area is a high-prevalence area for TB. This is determined by the local health authority.

In areas of low prevalence the provider will administer the TB Risk Questionnaire beginning at age 1 year and annually thereafter. TB skin testing should be done if the questionnaire indicates a risk factor, or if the provider determines that a skin test is appropriate.

In areas of high prevalence, TB skin testing should be administered at age 1, once between 4 and 6, and once between ages 11 and 16. If the client refuses the skin test or the child is uncooperative, administer the questionnaire. The questionnaire should be administered annually beginning at age two years and thereafter. In those age ranges where a skin test is recommended, the provider should administer the skin test at one of these ages and the questionnaire at the other annual check ups. The TB skin test should also be administered at these ages if a risk factor is indicated or if the provider determines a skin test is appropriate.

Tuberculin tests are to be performed in the provider's office or clinic. The materials (PPD-Mantoux antigen and syringe) are distributed free of charge to the provider upon request by the TDH's local or regional health departments. The cost of administering the test is included in the screening fee. If a follow-up screening visit is required to verify a presumptive positive reaction, the provider may bill the follow-up medical screening visit

fee. Diagnosis and treatment are provided as a Medical office visit. **TINE testing is not supplied by TDH and should not be used.**

Tests should be performed on adolescents who are contacts to a case of active TB, have lived in a homeless shelter, have been incarcerated or live with someone who has been incarcerated, have lived or visit regularly in an area endemic for TB, currently work in a health care setting, are a recent immigrant from a country with a high prevalence of TB, or have associated with someone with HIV infection.

The questionnaire is to be used at each adolescent screening THSteps visit. If any question on the questionnaire is answered with a "yes" or "I don't know," a TB skin test (Mantoux) is to be done at the visit unless medically contraindicated (e.g., has history of a previous positive PPD). If all questions are answered with a "no," the child/adolescent does not need to have skin testing unless the provider believes it is indicated for other medical reasons.

Any newly identified positive reactions should be evaluated by a screening provider or referred for evaluation. Any suspected cases or diagnosed cases of tuberculosis are to be reported to the local health department.

Refer to "TB Questionnaire" on page 2 and "Cuestionario Para la Detección de Tuberculosis" on page 2 of this guide.

3.8.9.1 Obtaining Questionnaires

You may photocopy the questionnaires from this publication or order copies (10 or less) from TDH THSteps Division at **512-458-7745**.

3.8.10 Laboratory Tests

Laboratory work for cholesterol screening, HIV testing, Gonorrhea/Chlamydia, and syphilis testing is performed by the Bureau of Laboratories, TDH. The Pap smear is performed by the Texas Center for Infectious Disease Cytopathology Laboratory Department. Laboratory specimen collection testing materials, and necessary forms and supplies are made available free of charge to all enrolled medical screening providers. The information presented here describes laboratory test procedures, interpretation of laboratory test results, guidelines and criteria for follow-up as well as helpful information on specimen collection and handling.

3.8.11 Hyperlipidemia Testing

3.8.11.1 Discussion

High blood cholesterol levels in childhood and adolescence clearly play a role in the development of coronary heart disease (CHD) in adults. Compelling evidence exists to indicate that the process of atherosclerosis begins in childhood, that this process is related to elevated levels of blood cholesterol, and that these levels are often predictive of elevated blood cholesterol in adulthood.

Various studies have shown that, compared to their counterparts in many other countries, U.S. children and adolescents have higher blood cholesterol levels and higher intakes of saturated fatty acids and cholesterol. Children and adolescents with high cholesterol levels are more likely than the general population to have high levels as adults. Despite substantial success in reducing CHD mortality in the past two decades, this disease remains the leading cause of death in the United States and results in more than 500,000 deaths annually. Preventing or slowing the atherosclerotic process in childhood and adolescence could extend the years of healthy life for many Americans.

For individuals in the following risk category, indicate that a lipid profile is needed on the laboratory request form. Do not request lipid profiles on individuals who are not in this risk category.

Adolescents who have a parent or grandparent with diagnosed coronary artery disease, peripheral vascular disease, cerebrovascular disease, angina pectoris, documented myocardial infarction or sudden cardiac death at age 55 or younger should be screened with a fasting lipoprotein analysis because a high proportion of these children will have some lipoprotein abnormality.

Cholesterol and triglycerides are water-insoluble lipids that are carried in the blood by particles called lipoproteins. Diet, genetics, and acquired factors may affect the circulating levels of one or more lipoproteins, thereby affecting levels of cholesterol, triglycerides or both. Three main classes of lipoproteins can be measured in the blood: very low density lipoproteins (VLDL), low density lipoproteins (LDL), and high density lipoproteins (HDL). LDL and HDL mainly transport cholesterol, and VLDL is the major carrier of triglycerides. Genetic abnormalities in the metabolic pathways of one or more lipoproteins may produce increases in the levels of cholesterol, triglycerides or both. However, a critical factor raising cholesterol levels in many individuals is the habitual dietary intake of excessive amounts of saturated fatty acids and cholesterol.

3.8.12 Laboratory Procedure

Specimens submitted for cholesterol screening are analyzed on an automated chemistry analyzer using a reagent system specific for the quantitative, enzymatic measurement of total serum cholesterol.

The lipid profile performed on at-risk adolescents includes the measurement of total blood cholesterol, triglycerides, and high density lipoproteins (HDL), as well as calculated value for the low density lipoproteins (LDL). These tests are also performed on an automated chemistry analyzer using reagent systems specific for these analyses.

IMPORTANT:
These services and supplies are limited to THSteps screening laboratory services provided in the course of an adolescent preventive health visit or follow-up visit for Medicaid/THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

3.8.13 Interpretation of Test Results

3.8.13.1 Cholesterol Screen

Cholesterol mg/dL	Interpretation	Refer for Follow-up Care
<170	Within desirable limits. Rescreen in five years.	No
170-199	Repeat cholesterol in 1-8 weeks Average the two results.	
	a. If average <170 mg/dL, rescreen in five years	a. No
	b. If average ≥ 170 mg/dL, individual may be at risk for developing hyperlipidemia and adult coronary heart disease.	b. Yes
≥200	Indicative of increased risk for developing hyperlipidemia and coronary heart disease.	Yes

3.8.14 Lipid Profile/At-Risk Patients

Desired Results	
Cholesterol:	<170 mg/dL
Triglycerides:	30-190 mg/dL
HDL:	>35 mg/dL
LDL:	<110 mg/dL

Once a lipoprotein analysis has been obtained, it should be repeated within 18 weeks to obtain averaged test results for cholesterol and LDL on the consecutive specimens. The averaged LDL result is considered the most significant indicator for ascertaining the risk status and therapeutic needs of these patients.

Average Total Cholesterol (mg/dL)	Average LDL (mg/dL)	Interpretation	Referral for Follow-up Care
<170	<110	Acceptable: provide education on recommended eating patterns and CHD risk factors, repeat lipoprotein analysis in 5 years.	No
170-199	110-129	Borderline: patient will need appropriate education, risk factor intervention, and diet therapy prior to reevaluation.	Yes
≥200	≥130	High-Risk: patient will need further evaluation for secondary causes and familial disorders, diet therapy, and in extreme cases, drug therapy.	Yes

Specimen Collection and Handling

Submit a full red-stoppered tube of blood. A separate tube must be submitted for this analysis, regardless of any additional THSteps laboratory screening procedures being performed at the same time.

Collection technique is a standard venipuncture method. After collecting the specimen, label the tube with the patient's first and last name as recorded on the laboratory request form. It is not necessary or recommended to centrifuge and separate the serum portion. If unable to mail within 24 hours, refrigerate the specimen, but do not hold for more than 3 days.

3.8.15 Gonorrhea/Chlamydia Infection Testing

3.8.15.1 Discussion

Gonorrhea and Chlamydia infections are the most common sexually transmitted diseases in the United States today. *Neisseria gonorrhoeae* is the bacterium that causes gonorrhea; *Chlamydia trachomatis* is the microorganism responsible for Chlamydia infection. Infection with either of these organisms usually results in an anterior urethritis accompanied by a purulent discharge in males. In females, these diseases usually infect the cervix; however, the vagina and uterus may also be involved. Asymptomatic, coexisting infections are frequently diagnosed, and for this reason, sexually active adolescents are tested for both these diseases simultaneously. Untreated infections may result in severe complications, including sterility and pelvic inflammatory disease.

3.8.15.2 Laboratory Procedure

TDH laboratory uses the Gen-Probe Pace 2C system to screen for gonorrhea and Chlamydia infection. This methodology utilizes DNA probe technology and permits testing for gonorrhea and Chlamydia infection from a single swab.

The laboratory procedure is based on the alignment of the target microorganism's ribosomal RNA with complementary single-stranded DNA probes. If either microorganism is present in the sample, a stable DNA:RNA hybrid will form as the organism's RNA aligns with one of the chemiluminescent labeled DNA probes. The labeled DNA:RNA hybrid is magnetically separated from the nonhybridized DNA probe and then measured for chemiluminescence. Test results are calculated from the difference between the response of the specimen and the mean response of negative reference specimens. A positive or indeterminate specimen is retested with the single-organism specific Gen-Probe Pace 2 system to identify the specific organism that is causing the infection.

This procedure avoids the need for culturing the specimen to recover the microorganisms, thus permitting faster laboratory turnaround and lower unsatisfactory specimen rates. The Gen-Probe Pace 2 system has been used successfully at the TDH laboratory since 1991, due to the excellent sensitivity and specificity of the procedure.

3.8.15.3 Interpretation of Test Results

A positive result for either gonorrhea or Chlamydia infection indicates the presence of infection and a need for patient referral and treatment. It must be understood, however, that this screening procedure may yield a low percentage rate of false-positive results. Therefore, it is advisable to repeat the Gen-Probe screening test or perform a culture test on specimens from low-risk patients who have no typical symptoms or history of exposure but who demonstrate a positive screening test result.

IMPORTANT:
*THSteps providers are advised that specimens associated with medicolegal problems are **not** to be tested with the Gen-Probe Pace 2 methodology.*

Negative results indicate absence of the infection. Although the Gen-Probe procedure has been evaluated as a very reliable procedure, the validity of the results can only be as good as the quality of the specimen. A negative result does not exclude the possibility of infection because test results may be affected by improper specimen collection. Any individual who claims recent exposure to gonorrhea or Chlamydia should be treated prophylactically.

Unsatisfactory results may occur when:

- Transport fluid leaks from the tube during mailing.
- The incorrect swab is used for the gender of the patient. The quantity of fluid in the male collection kit is different from that in the kit designed for females. It is critical to use the correct collection kit.
- Swabs are collected from oral or rectal sites. These are not suitable specimens for this procedure.
- Specimen contains a gross quantity of blood. In general, bloody specimens can be tested, but large amounts of blood may interfere with assay performance and will be noted on the laboratory report.
- Collector is submitted without a swab or with multiple swabs
- Specimen arrives more than 7 days after collection

3.8.15.4 Specimen Collection and Handling:

A) Collect swab specimens as follows:

1) Cervical Swab Specimens

   a) Using a female collector, remove excess mucus from the cervical os and surrounding mucosa using one of the swabs in the kit or a jumbo (Proctor) swab- discard this swab.

   b) Insert the second swab from the collection kit 1 to 1 1/2 cm (1/2 to 3/4 inch) into the endocervical canal.

   c) With mild pressure, rotate the swab through several 360 degree rotations in both directions in the endocervical canal to ensure adequate sampling. Leave the swab in for 10-30 seconds.

   d) Withdraw the swab carefully, avoiding any contact with the vaginal mucosa.

   e) Insert the swab into the Gen-Probe Transport Tube; break off or cut swab shaft to fit the tube and cap the tube separately.

2) Urethral Swab Specimens

   a) Using a male collector, collect a specimen only from patients who have not urinated for at least one hour.

   b) Collect the urethral specimen by inserting the swab from the urethral collection kit 2-4 cm (3/4 to 1 1/2 inches) into the urethra, using a rotating motion to ease insertion.

   c) Rotate the swab gently, using sufficient pressure to ensure that the swab contacts all urethral surfaces; allow the swab to remain inserted for 2-5 seconds.

   d) Withdraw the swab.

e) Insert the swab into the Gen-Probe Transport Tube; break off or cut the swab shaft to fit the tube and cap the tube securely.

3) Conjuctival specimens - swab any area appearing inflamed or infected. Specimens will be tested for Chlamydia only.

Label the specimen transport tube with the patient's first and last names. Prior to mailing, be sure that the cap is tight. Leakage of the transport fluid will result in an unsatisfactory specimen. **Provide all information requested on the test request form**.

B) Mail the collection tubes daily to the TDH laboratory. If unable to mail within 24 hours, the specimen should be refrigerated. Do not hold for more than 3 days. The collection tubes should not be frozen, nor reach temperatures above 85 degrees Fahrenheit. Swab specimens **must reach** the testing laboratory within **seven days** after collection.

3.8.16 Syphilis Testing

3.8.16.1 Discussion

Syphilis testing should be performed on adolescents who are at high risk for infection. This includes sexually active individuals living in an area with a high prevalence of STD, endemic for syphilis or individuals at risk, (e.g., past family history or prior history of other sexually transmitted diseases, and/or on adolescents who have had vaginal, anal, or oral sex, or having had a sexual partner who is at risk for infection).

3.8.16.2 Laboratory Procedure

A Rapid Plasma Reagin (RPR) Card Test is the screening procedure for detecting the presence of syphilis.

A venipuncture sample using a 7mL clot tube (red stopper) is required. The provider should note the following:

- The RPR Card Test is a macroscopic nontreponimal testing procedure similar in sensitivity and reliability to VDRL.
- False positive reactions occur with variable frequency as a result of reagin produced in diseases other than syphilis or provoked by immunization antigens.
- The RPR Card Test cannot be performed if hemolysis of the sample has occurred or if sample volume is less than 0.5mL.

Specimens found reactive by RPR Card Test are confirmed for syphilis by Trepnema pallidum-particle agglutination (TP-PA) tests or Fluorescent Treponemal Antibody Absorbed (FTA) tests.

3.8.17 HIV Testing

3.8.17.1 Discussion

It is critical to maintain patient confidentiality in caring for these patients and their specimens due to the sensitive nature of this testing. Do not leave specimens identified for HIV testing in open view of unauthorized medical personnel. Discussions with patients regarding their risk factors should be handled with confidentiality. Testing should be performed only after informed consent is obtained from the adolescent. Do **not** mail patient consent to the laboratory - retain with patient records.

HIV testing may be performed on adolescents without requirement of parental consent.

Adolescents at risk for human immunodeficiency virus (HIV) infection should be offered confidential HIV screening.

Pregnant females are required to be tested for HIV, syphillis, and hepatitis B at their first prenatal visit and/or at delivery unless the client objects. The law requires that the client first be verbally informed of the test and of her right to refuse testing. If the client refuses to be tested, the provider is required to explain the option of anonymous testing and refer the woman to a testing facility that offers such testing. The provider must also furnish the

client with educational material about HIV, AIDS, and syphilis. A notation must be made in her medical record that the distribution of materials was made and that verbal notification of the HIV test and the right to refuse was given.

If a test indicates that the pregnant client is infected with HIV, the provider must give the woman information about the treatment of HIV/AIDS. The law requires that the information be presented in a way that will allow for understanding by the client.

- Risk status includes having used injectable drugs, having had other sexually transmitted disease (STD) infections, having been sexually active and having lived in an area with a high prevalence of HIV and other STD infections, having had vaginal or anal intercourse with more than one sexual partner, having exchanged sex for drugs or money, or having had a sexual partner who is at risk for HIV infection.
- The frequency of screening for HIV infection should be determined by the risk factors of the individual.
- Testing should be performed only after informed consent is obtained from the adolescent.
- Pre- and post-test HIV prevention counseling will be made available to include health guidance regarding responsible sexual behaviors, including abstinence.

Pre- and post-test counseling should include:

- Counseling that abstinence from sexual intercourse is the most effective way to prevent pregnancy, STDs, and HIV infection.
- Counseling on how HIV infection is transmitted, the dangers of the disease, and the fact that using latex condoms reduces the risk of transmission of HIV and other STDs.
- Reinforcement of responsible sexual behavior for adolescents who are not currently sexually active and for those who are using birth control and condoms appropriately.
- Counseling on the need to protect themselves and their partners from pregnancy, STDs, HIV infection, and sexual exploitation.

3.8.17.2 Laboratory Procedure:

The presence of HIV-1 antibodies in patient serum is a long-term marker of infection. Specimens are tested on an enzyme immunoassay (EIA) that identifies patient antibodies that are specific for the HIV-1 virus. Specimens that are initially reactive on the EIA screen are retested in duplicate on the EIA. If either of the duplicate retests are reactive, the EIA is considered repeatedly reactive and a confirmatory test, the Western blot, is performed. The Western blot involves the separation of the virus proteins by size on a special strip of filter paper. This strip is soaked in a dilution of patient serum. If antibodies specific for the different proteins are present, they will bind to that portion of the strip. The antibodies are then detected with enzyme-labeled antibodies that cause a darkening on the strip where patient antibodies have bound. Western blot bands are named by a letter indicating the type of molecule, p = protein, gp = glycoprotein, and a number that indicated their relative size in kilodaltons (for example, p17 = a protein 17 kilodaltons in size).

3.8.17.3 Interpretation of Laboratory Results

Laboratory report forms will state whether the HIV-1 EIA result is nonreactive, reactive, or unsatisfactory. Interpretation of a nonreactive EIA result must take into consideration recent risk factors of the patient; a period of time from exposure (as soon as six weeks, but up to six months) is required before antibodies will be produced to the virus in detectable quantities. This process is called seroconversion or the window period. A reactive EIA result will also have an attached report of the Western blot test result which may be nonreactive, reactive, or indeterminate. The minimum criteria for a reactive Western blot is antibodies present for any two of the following viral protein bands: p24, gp41, gp120/160. Indeterminate Western blot patterns will not meet the minimum criteria and while not common, this may be an indication of seroconversion taking place. This is the reason for retesting the patient after 8 weeks.

3.8.17.4 Specimen Collection and Handling

Submit a full red-stoppered tube of blood. A separate tube must be submitted for this analysis, regardless of any additional THSteps laboratory screening procedures being performed at the same time.

Collection technique is a standard venipuncture method. After collecting the specimen, label the tube with the patient's first and last name as recorded on the laboratory request form. It is not necessary or recommended to centrifuge and separate the serum portion. If unable to mail within 24 hours, refrigerate the specimen, but do not hold for more than 3 days.

3.8.17.5 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases, including HIV, are reportable conditions under Title 25 Texas Administrative Code (TAC), Chapter 97. Providers should report confirmed diagnosis of STDs as required by 25 TAC 97.132.

3.8.18 Cervical Cancer Screening

3.8.18.1 Discussion

The Papanicolaou (Pap) smear test is a microscopic examination of cells exfoliated or scraped from a mucosal surface. This test is most widely used in detecting malignant, premalignant and inflammatory disease of the uterine cervix.

3.8.18.2 Laboratory Procedure

Pap smears arrive by mail at the Women's Health Laboratories and are delivered to the Cyto-pathology department of the laboratory. The specimens are sorted by provider and assigned an accession number. The slides are stained with the Pap stain technique and coverslipped. Staff cytotechnologists examine all Pap smears for cellular disease and render a diagnosis on those determined to be negative or abnormal. Ten percent of the cases considered negative and all of those considered abnormal by the staff cytotechnologists are rescreened by a quality control cytotechnologist. All abnormal cases are referred to a pathologist for final interpretation and follow-up recommendation. A computer generated results report is then mailed to the submitting THSteps Screening provider. A statistical card is mailed monthly to providers documenting their totals by diagnosis.

Test:	Cervical, Vaginal And Vulva Pap Smears For Cytologic Evaluation
Patient Preparation:	A carefully obtained smear will provide the cytologist with an optimal specimen for interpretation. A pap smear should be obtained under the following ideal conditions when possible.
1.	The patient is not menstruating.
2.	Nothing has been placed in the patient's vagina during the past 24 hours.
3.	The pap smear is the FIRST specimen collected if multiple specimens are to be obtained.

Materials:	
Glass slide with frosted end (label patient's name, birth date and source of specimen on frosted end)	
Cardboard container	Spatula, AYRE's type with extended tip
Cytobrush (DO NOT USE ON PREGNANT PATIENTS)	Spray fixative
Speculum	Gloves
Pencil #2	Requisition slip

Precautions:	
1.	Smears should not be thick or bloody.
2.	Smears should be “fixed” immediately.
3.	If more than one source is sampled, identify slides with source of specimen.
4.	The margins and not the button of a grossly ulcerated area should be scraped.
5.	The area where there is history of irradiation, of prior biopsy or treatment should be scraped.

3.8.18.3 Procedure for Cervical Smear

1) Explain the process of pelvic examination and pap smear to the patient.
2) Insert speculum until appropriate view of cervix and vaginal wall is obtained. DO NOT USE LUBRICATION other than a minimal amount of water or normal saline. Visually examine cervix and vaginal wall.
3) Obtain portio specimen. Place the end of the spatula on the portio and rotate through 360 degrees several times, scraping the surface to include the entire transformation zone. Spread the material evenly over the entire slide.
4) Obtain endocervical specimen. The cytobrush is the preferred instrument, however a saline moistened cotton swab may be used instead, particularly in the pregnant patient. Insert one cytobrush or cotton swab into the endocervical canal and rotate several times. Then roll the sample evenly over the entire slide applying it over the portio sample.
5) Step 3 and 4 should be done carefully; but quickly. Once both specimens have been applied to the slide, they should be spray fixed within a few seconds.
6) Place slide in a cardboard container. Allow slide to dry completely before closing container, otherwise, the slide may stick to the surface of the cardboard with an increased chance of breakage during transport. The cardboard fiber can also absorb moisture from the smear and result in air dried cells.

3.8.18.4 Request Form:

1) A cytology request form (Form M-47) is to be submitted.
2) Make sure slide and request forms are appropriately labeled. Wrap completed M-47 form around cardboard mailer and fasten with rubber band.
3) Completed M-47 form must include:
   a) Pertinent patient information
   b) Pertinent provider information
   c) Requesting provider
4) Completed cytology request form must include patient information for billing purposes.
5) Slide should be labeled with the patient’s last name, first name and birthdate.

3.8.18.5 List of Supplies for Obtaining Pap Smears

Provided by TDH

THSteps providers can order supplies for obtaining Pap smears for THSteps adolescent screening from:

Women's Health Laboratories
ATTN: Kathy Allen, Cytology Lab
2303 SE Military Drive
San Antonio TX 78223
210-534-8857 ext 2357

- Use order Form AG-30 or 1643 or letterhead stationary
- Include your THSteps provider number

Supplies which are sent include:

1) Frosted Slides
2) Cyto Cervical Brush
3) Cyto Fixative
4) Cardboard slide mailers
5) M-47 Forms
6) Cervical Scrapers
7) AG-30 (Order Forms sent to provider site)

NOTE:
Providers who are already on the automated system through the TDH Pharmacy division are requested to continue to use this system. Larger numbers of supplies are sent through the TDH pharmacy.

3.8.18.6 Interpretation of Test Results:

1) Specimen Upon Receipt - Refers to the condition of the glass slide and request form upon receipt whether it is ADEQUATE or OTHER. OTHER signifies that the slide or request form is not satisfactory and an explanatory comment will follow.
2) Statement of Adequacy - Refers to the adequacy of the cellular sample. One of three possible statements will be given to describe the adequacy of the specimen:
   - SATISFACTORY - Indicates the specimen is satisfactory for interpretation.
   - SATISFACTORY BUT LIMITED BY - Indicates the specimen is satisfactory for interpretation but limited by scant cellularity, poor fixation/preservation, obscuring inflammation or blood, cytolysis/autolysis, or no endocervical component.
   - UNSATISFACTORY - Indicates the specimen is unsatisfactory for interpretation, a reason(s) will be given.
3) Cytology Diagnosis - Refers to the primary interpretation of the sample:-
   - NEGATIVE FOR TUMOR CELLS - Used when no epithelial abnormalities are found.
   - ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE - Consists of atypical squamous cells in which it is difficult to distinguish between a reactive or premalignant process.
   - ATYPICAL GLANDULAR CELLS OF UNDETERMINED SIGNIFICANCE - Consists of atypical glandular cells of endocervical origin, endometrial origin or origin not specified.
   - LOW GRADE SQUAMOUS INTRAEPITHELIAL LESION - Consists of epithelial abnormalities with descriptive diagnosis of Human Papilloma Virus (HPV) and/or Mild Dysplasia.
   - HIGH GRADE SQUAMOUS INTRAEPITHELIAL LESION - Consists of epithelial abnormalities with descriptive diagnosis of Moderate Dysplasia, Severe Dysplasia or Carcinoma in Situ (CIS).

- POSITIVE FOR MALIGNANCY - Used when malignancy is diagnosed, squamous cell carcinoma, adenocarcinoma or other neoplasm.

4) Other Findings - Refers to benign findings that may be found with any cytology diagnosis and may include the following:

- INFECTION - Trichomonas, candida, coccobacilli, Actinomyces, or herpes.
- REACTIVE CHANGES - Consists of epithelial changes associated with inflammation, atrophy, or radiation.

3.8.19 Follow-Up Checkup

A follow-up checkup visit is reimbursed at a maximum fee of $6 when required to complete necessary procedures related to the initial medical checkup or adolescent preventive service visit (for example, verification of a presumptive positive TB skin test, transportation, and outreach work required by provider for verification of a presumptive positive TB skin test, administering immunizations in cases where the child's immunizations were not up-to-date or medically contraindicated on the initial visit, and repeating laboratory work). An additional $5 administrative fee is paid for each immunization (injection) administered. Combined antigen vaccines (for example, DTaP, MMR) are reimbursed as one dose. A return visit to follow up on treatment initiated during the screen or to make a referral is not to be filed as a follow-up visit.

3.9 THSteps-CCP

If children under 21 years are found to have abnormal results on the THSteps Check-Ups, Screenings, or Laboratory Tests, the Texas Medicaid Program also provides funds for appropriate follow-up care.

The physician who has provided the THSteps check-up may be able to diagnose and treat the finding in his or her office. In the Medicaid fee-for-service program, information regarding coding and billing for these services may be found in the *Texas Medicaid Provider Procedures Manual*.

When abnormal findings a require referral for diagnosis and treatment by specialty providers, the physician may be able to do that directly, or may need to get prior approval from the TDH or its designee, NHIC. For services that are covered under the traditional Medicaid program, instructions are in the manual.

For those services that are covered under the Texas Health Steps-Comprehensive Care Program (THSteps-CCP), the primary and/or specialty providers must contact TDH or NHIC for prior approval. For example, the THSteps - CCP Program covers private duty nursing, customized durable medical equipment, developmental therapies, inpatient psychiatric services, outpatient psychiatric services beyond traditional Medicaid benefits, nutrition counseling, and unlimited pharmaceuticals. These services require documentation of medical necessity and prior approval.

The Texas Medicaid Program continually reviews current policies and requests for coverage of new health and health-related services. When Medicaid policies are revised or adopted information and implementation instructions are published in the bimonthly *Texas Medicaid Bulletin*.

For Medicaid eligible children who are enrolled in a Medicaid Managed Care Organization (MCO), all the same benefits must be provided as described in the *Texas Medicaid Provider Procedures Manual*. Reimbursement and precertification requirements are negotiated through contracts and other agreements between the State of Texas or one of its contracting MCOs and the providers. Providers are referred to the appropriate Provider Manuals of the Medicaid MCOs. Providers may contact the TDH, either through the Program offices in Austin (such as the Bureau of Managed Care) or the Regional offices. Contact persons and numbers are given in Section 1 of *Texas Medicaid Service Delivery Guide*.

4

THSteps - Dental

THSteps - Dental

Texas Health Steps (THSteps) is the Texas version of the Medicaid program known as EPSDT. The Dental care benefits are available to Medicaid eligible children up to the age of 21 years.

4.1 Enrollment

To enroll in the Medicaid THSteps Dental Program, providers must be Texas licensed dentists (D.D.S.) or dental hygienists practicing within the scope of their professional licensures.

4.2 How the Program Works

THSteps designated staff (TDH, TDHS, or contractor), through outreach and information, encourage eligible children to use THSteps dental check-ups and prophylactic care when they first become eligible for Medicaid and each time they are periodically due for their next dental check-up.

Upon request, TDH (or its contractor) will assist eligible children with scheduling and transportation. Children within regular Medicaid have free choice of providers, and are given names of enrolled providers. Call **800-846-3707** for a list of THSteps dental providers in a specific area.

When the child is eligible for a THSteps dental check up, a "✓" (check mark) will be present on the Medicaid Identification Form (2087) next to "dental." If the child or care giver believes the child is due for a dental check-up and a "✓" is not present, the provider may contact NHIC for verification through TexMedNet or AIS.

A child begins eligibility for THSteps dental check-ups at 12 months, and is eligible every six months thereafter, up to age 21 years.

If the child presents with an acute dental health need, but is also eligible for a THSteps dental check-up prophylaxis, those services can be provided and billed to the Texas Medicaid Program as well. Submit all dental service claims to:

EDS/NHIC
12545 Riata Vista Circle
Austin TX 78727

4.3 Dental Assessment Guidelines

The applicable periodicity schedule for THSteps Dental Screening follows the standards as adopted by the American Academy of Pediatric Dentistry. The initial dental screen by the medical provider, as required within the Comprehensive THSteps Medical Examination, should occur at 1 year of age or when first teeth have erupted, and each visit thereafter. The medical checkup must initiate the referral for the more comprehensive THSteps Dental Exam by a THSteps participating dentist, starting at age one and every 6 months there after (unless unusual circumstances dictate more frequent referrals). Eruption pattern evaluation by the medical provider can be a valued diagnostic tool. A delayed eruption pattern of 6-12 months should be evaluated by the medical provider for potential medical/nutrition etiology. An eruption pattern and sequence chart is provided in the appendices of this section of the manual.

To reduce the risk of Baby Bottle Tooth Decay (BBTD), the infant and early childhood patient should be evaluated for incipient decay, characterized by a faint white or brown hue, through advanced decay of the upper anterior teeth. If decay is noted, the parent/care provider should always be counseled in proper bottle feeding practice. Controlled and scheduled bottle feeding frequency, duration of feeding and bottle content (low sucrose)

are excellent preventive measures for BBTD. Feedings should be followed by gentle cleansing of the oral structures with a damp washcloth or small soft brush. The parent/care providers should establish a goal to have the child drinking from a cup and not needing a bottle by the first birthday.

Children with developing primary or mixed (primary-permanent) dentition should be evaluated for caries. They should also be evaluated for soft tissue complications. Various systemic diseases are commonly initially expressed by changes in the soft tissues of the oral structures. Red, swollen and/or tender gingiva (gums), while typically indicating nothing more than poor oral hygiene practice, can also be indicators of a need for more detailed systemic health evaluation. Palpation of the submandibular lymphatic system for lymphadenopathy is a valued tool in the dental portion of the screen. Consultation with a dental provider, where a differential diagnosis may apply, is highly recommended by the THSteps Program. Many studies have shown that dental sealants, when properly applied to the pits and fissures of a permanent molar, can protect the tooth from decay.

Adolescent THSteps patients benefit not only from the evaluation of eruption pattern, decay prevalence, and oral hygiene practice, but also from other comprehensive observations. Hormonal changes of the body at adolescence often precipitate amplified oral soft tissue changes. Soft tissue irritants in these adolescent patients can provoke significant tissue responses. Patients with diabetes and patients under long-term medications therapy should be educated in potential gingival manifestations if daily oral health hygiene practice is not observed. Physician reinforcement of the need for thorough daily oral hygiene practices, as well as utilization of the THSteps eligibility for dental services, can greatly benefit the client.

The prevalence of the use of smokeless tobacco products by teens and preteens creates a high need to evaluate the patient for deterioration of oral hard and soft tissue. Examination of the mucobuccal fold (cheek area) and sublingual area for leukoplakia is indicated. White to various stages of edematous red patches can be readily identified and pointed out to the patient, and assistance offered in cessation, with minimal office time involvement. Oral cancer prevalence is expanding in many population groups. Early intervention and reinforcement of the need for cessation by the medical community have been shown to have a significant positive impact on the "early user."

In all cases and ages, the appropriate practice is to initiate a referral to a participating THSteps dental provider. Assistance in coordinating the referral can be obtained from the NHIC Assistance Hotline, or TDH Regional THSteps Coordinator for the respective region (lists provided in the appendices of the *Texas Medicaid Provider Procedures Manual*).

With the current knowledge and technology available to the dental profession, it is generally accepted that dental disease in children can be prevented through the application of various intervention techniques. Perhaps the two most important interventions are early and periodic dental examinations, and parent education which stresses to parents the important role they can play in preventing dental disease in their children. A study conducted by the Infant Oral Health Program at the University of Iowa's Department of Pediatric Dentistry substantiates these observations.

The Infant Oral Health Program study reached several significant conclusions. One primary conclusion relates to the importance of providing children with a pleasant, non-threatening introduction to dentistry. This was accomplished during the children's first visit, and subsequent visits to 30 months of age, by using the knee-to-knee position when conducting examinations (parent holds child on his/her lap and leans child back so the child's head is in doctor's lap; parent may hold the child's arms, if needed), followed by a demonstration for the parents of the technique and positioning of the child for tooth cleaning. The positive experiences of children examined in this way, and the opportunity for parents to participate in the process, seem to make it easier for parents to comply with tooth cleaning recommendations and suggestions for eliminating detrimental bottle feeding habits. This study highlights the need for the doctor to provide anticipatory guidance to the parent, emphasizing that the child should be off the bottle by age 1, and definitely should not be put to bed with a bottle.

Regularly positioned teeth with normal occlusion add symmetry and harmony to the facial appearance, and they are an important aspect of the expression of emotion and personality.

4.3.0.1 Primary Teeth

Primary teeth are also called deciduous or baby teeth. There are 20 primary teeth. They serve as guides so the permanent teeth will erupt in their proper positions.

Before the permanent teeth erupt, the primary teeth roots begin disappearing through a process called resorption. That is why the primary teeth appear to have no roots at the time they are shed.

Premature loss or delay in shedding primary teeth may result in crooked permanent teeth, irregular and unattractive facial features when older, and increased cost of dental service. If a primary tooth is lost prematurely, a dentist can replace it with a space maintainer to prevent teeth on either side from drifting inward and causing the permanent tooth to erupt in an incorrect position.

4.3.0.2 Permanent Teeth

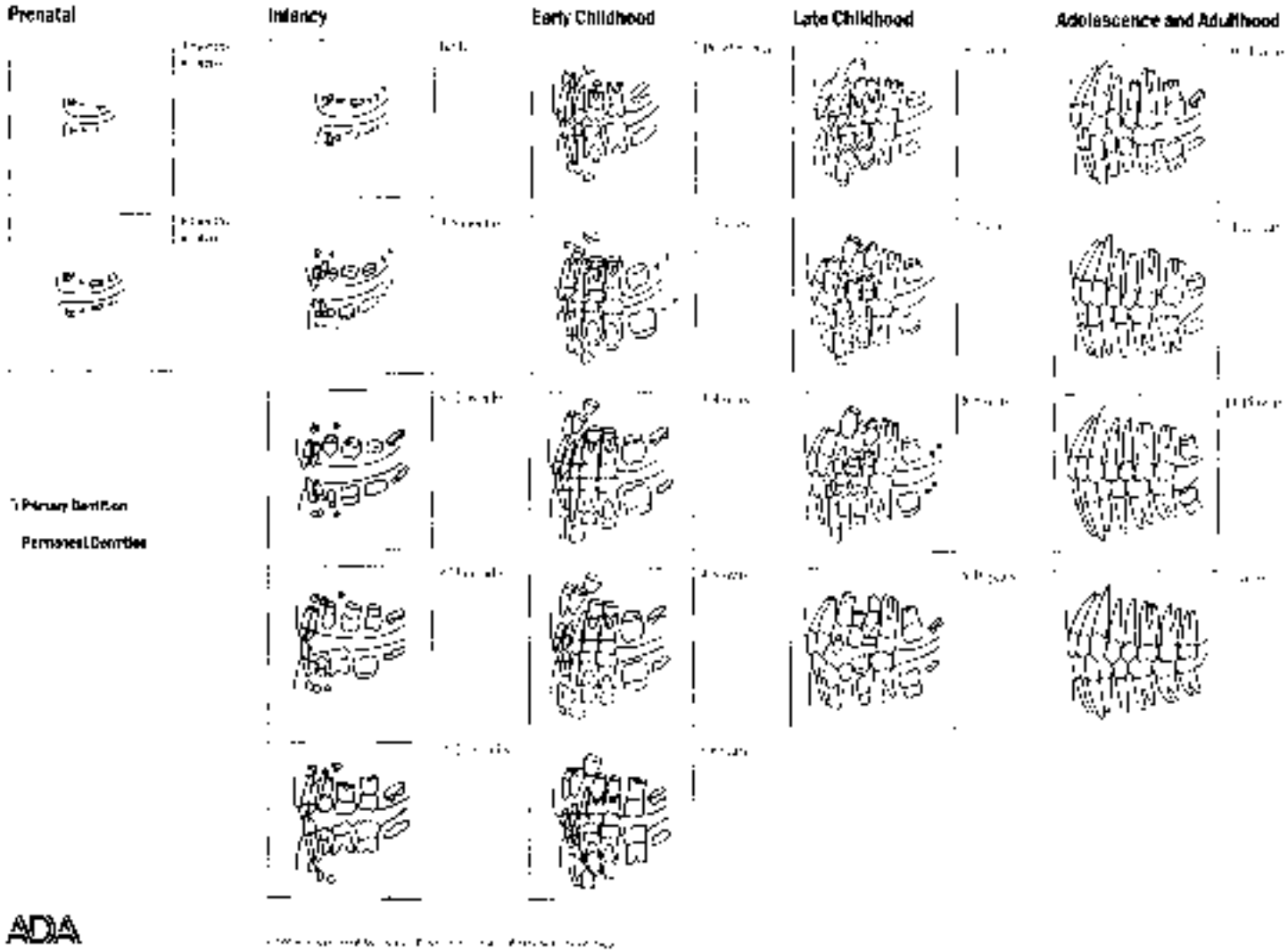
Because no two children are alike, some children will be slower in erupting and shedding teeth. The first permanent tooth is the six-year molar, which is the sixth tooth from the mid-line between the central incisors. There are four of them, and they erupt when the children are five or six years old. The first permanent molar is often mistaken for a primary tooth because no tooth is lost. These teeth are termed the keystones of the dental arches because they come into the child's mouth at such an early age that they help the other teeth come into their places in proper alignment.

4.4 Follow-Up Dental Care and Referrals

If a THSteps dental check-up reveals a dental health condition that requires follow-up diagnoses or treatment, the provider performing the dental check-up should assist the recipient in planning follow-up care or in making a referral to the qualified provider. The *Texas Medicaid Provider Procedures Manual* provides information regarding covered benefits, getting assistance to identify qualified providers, and how to code and bill for services covered by the THSteps program, the THSteps-Comprehensive Care Program (CCP), or the traditional Medicaid program.

For service delivery areas where the Medicaid eligible children are enrolled in a Health Maintenance Organization (HMO), the dental care will be provided by fee-for-service providers, however, other providers, such as the facility and anesthesiology care must be by HMO network providers or prior approved by the HMO.

4.4.1 Development of Human Dentition Chart



5

Immunizations

Immunizations

5.1 Overview

Children must be immunized during medical checkups according to the Recommended Childhood Immunization Schedule for the United States. The checkup provider is responsible for the administration of immunizations and must not refer children to local health departments. TDH requires that immunizations be administered unless they are medically contraindicated or are against the religious beliefs of parents.

A $5 administration fee is paid for immunizations given during a THSteps checkup or as part of a follow-up visit.

THSteps providers should bill for each vaccine separately. If administering a combined vaccine, such as DTaP (diptheria, tetanus, and pertussis vaccine), do not bill separately for each antigen.

The Immunization Division of TDH provides vaccine, Vaccine Information Statements, and other services and literature to children who receive services under THSteps. Federal mandates require that Vaccine Information Statements inform parents and vaccine recipients of the risks and benefits of vaccines they are about to receive. Providers must not only provide these statements before administering a vaccine but also ensure that the statements are the most current available. Call the Immunization Division at **800-252-9152** with any questions regarding immunizations, literature, or forms.

5.2 Recommended Childhood Immunization Schedule

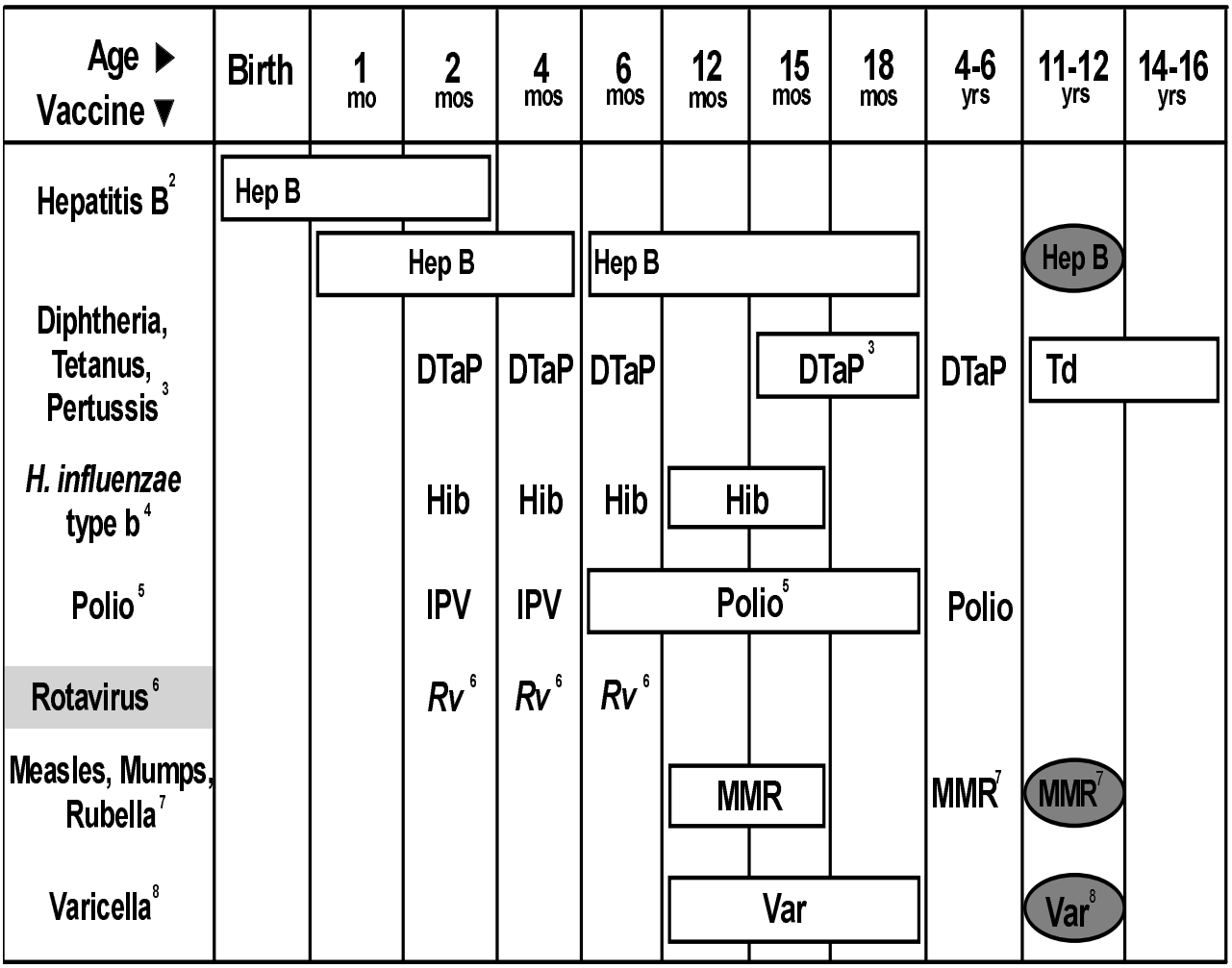
The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. It is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturers' package insert for detailed recommendations.

Vaccines[1] are listed under routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Recommended Childhood Immunization Schedule United States, January - December 1999

Vaccines[1] are listed under routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Note: ACIP issued the following statement concerning rotavirus vaccine on October 22, 1999: "The Advisory Committee on Immunization Practices (ACIP) recommended today that Rotashield, the only U.S.-licensed rotavirus vaccine, no longer be recommended for infants in the United States.

[1]This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2]*Infants born to HBsAg-negative mothers* should receive the 2nd dose of hepatitis B (Heb B) vaccine at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months of age.

Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

3DTaP (diptheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the immunization series, including completion of the series in children who have received 1 or more doses of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose (DTP or DTaP) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and if the child is unlikely to return at age 15-18 months. Td (tetanus and diptheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 years.

[4]Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax®[Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.

[5]Two poliovirus vaccines currently are licensed in the United States: inactivated poliovirus (IPV) vaccine and oral poliovirus (OPV) vaccine. The ACIP, AAP and AAFP now recommend that the first two doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of two doses of IPV administered at ages 2 and 4 months, followed by two doses of OPV at 12-18 months and 4-6 years. Use of IPV for all doses also is acceptable and is recommended for immunocompromised persons and their household contacts. OPV is no longer recommended for the first two doses of the schedule and is acceptable only for special circumstances such as: children of parents who do not accept the recommended number of injections, late initiation of immunization which would require an unacceptable number of injections, and imminent travel to polio-endemic areas. OPV remains the vaccine of choice for mass immunization campaigns to control outbreaks due to wild poliovirus.

[6]Rotavirus (Rv) vaccine is shaded and italicized to indicate: 1) health care providers may require time and resources to incorporate this new vaccine into practice; and 2) the AAFP feels that the decision to use rotavirus vaccine should be made by the parent or guardian in consultation with their physician or other health care provider. The first dose of Rv vaccine should not be administered before 6 weeks of age, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at 7 months of age or older, and all doses should be completed by the first birthday.

NOTE:
Rotavirus vaccine has been withdrawn from the market, and is no longer available. It is not currecntly a benefit of the Medicaid program.

[7]The 2nd dose of measles, mumps and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning

at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

[8]Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.

5.2.1 Varicella

The TVFC program now provides varicella vaccine to all eligible children who are one through 18 years of age. Susceptible household contacts of immunocompromised individuals may also be vaccinated with vaccine provided by TVFC, regardless of age.

5.2.2 Hepatitis B

REFER TO:
"Recommended Childhood Immunization Schedule" on page 5-3.

Infants who did not receive dose 1 of hepatitis B vaccine in the hospital or birthing center are to be immunized with the following schedule:

Dose 1 Hepatitis B*	1-2 months
Dose 2 Hepatitis B*	4 months
Dose 3 Hepatitis B*	6-18 months
*** Use appropriate Hepatitis B vaccine formulation and dose.**	

The TVFC program now provides Hepatitis B vaccine to THSteps children from birth through 18 years of age. TVFC vaccine may also be used to complete the series in later years for children who began the series while 18 or older.

Providers must purchase a private supply of Hepatitis B Vaccine for THSteps children who are 19 years or older, and who are **beginning** the Hepatitis B vaccination series. Providers should use 9-5739X billing code.

IMPORTANT:
Important for Adolescents. The 0, 1, and 6-month intervals between vaccines preferred; however, alternative schedules (0, 2, and 4 months) may be used to achieve a complete hepatitis B vaccine schedule.

There is no change in the protocol for management of newborns with perinatal exposure; newborns whose mothers are Hepatitis B Surface Antigen (HBsAg) positive. All pregnant women should be screened for HBsAg as early as possible in their pregnancy. Asymptomatic HBsAg positive women, with or without pertinent hepatitis history, should be referred immediately to the nearest local health department or TDH Regional Immunization Program office for contact screening, immunizations, and for immunotherapy for the newborn. You may call the TDH Perinatal Hepatitis B Coordinator at **800-252-9152** for a referral to help with follow-up of high-risk infants and children.

Neonates with perinatal exposure require timely immune therapy consisting of 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of delivery or within seven days postpartum and the correct dose of hepatitis B vaccine for a high-risk infant. Refer to the following chart for recommended doses.

5.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the January 28, 1994 issue of the Morbidity and Mortality Weekly Report (MMWR), General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices (ACIP). For copies of the General Recommendations on Immunization, contact the Immunization Division **512-458-7284** or **800-252-9152**.

5.3.1 Hepatitis A

For 32 counties along the Texas-Mexico border, hepatitis A vaccine is now a routinely recommended vaccine. The Texas Vaccines for Children Program provides hepatitis A vaccine for eligible children 2 through 18 years of age who reside or attend school or child care facilities in the 32 county area.

The affected counties are Brewster, Brooks, Cameron, Crockett, Culberson, Dimmit, Duval, Edwards, El Paso, Frio, Hidalgo, Jeff Davis, Jim Hogg, Kenedy, Kinney, La Salle, Maverick,

McMullen, Pecos, Presidio, Real, Reeves, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

For all other counties in Texas, hepatitis A vaccine is not a routine childhood vaccine. The vaccine is provided based on medical necessity and documented need of the community. Providers should contact their regional or local health department to find out if they are in areas with a documented need for the vaccine.

5.3.2 Polio Vaccine

The Advisory Committee on Immunization Practices, the Centers for Disease Control and Prevention, the American Academy of Pediatrics, and the American Academy of Family Physicians, have announced that effective January 1, 2000, the Recommended Childhood Immunization Schedule for the United States will be revised from the sequential inactivated polio vaccine (IPV)/oral polio vaccine (OPV) series to an all-IPV recommendation.

Since 1979, the only indigenous cases of poliomyelitis reported in the United States have been associated with the use of live-virus OPV. Until recently, the benefits of OPV outweighed the risks. The global eradication of polio has progressed rapidly and the risk of polio importation into the United States has decreased substantially.

The effective date in Texas may be sooner than January 1, 2000, because current inventory levels of OPV may be depleted before that date, and OPV may no longer be available to purchase in large quantities. Once all inventories of OPV are depleted, future shipments will consist of IPV only.

5.3.3 How to Obtain Free Vaccines

TDH provides vaccines for immunization of THSteps patients free of charge to THSteps medical screening providers and other qualified Medicaid providers through the local health department/district and regional offices of TDH. The local health department/district or TDH regional office provides information on how to order, account for, and inventory vaccines. If the requested reports are not received on a monthly basis, the provider will not be supplied with state purchased vaccines. Physicians who request and accept state supplied vaccines must complete and sign on an annual basis the Statement of Understanding/Agreement by Private Physicians and Organizations Receiving State and Federally Funded Vaccine.

Providers are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a child for an immunization. These statements are specific to each vaccine and inform the responsible adult about its risks and benefits. It is very important that providers use the most current VIS.

Providers interested in obtaining copies of current statements or any other immunization forms or literature may call the Immunization Division of TDH at **800-252-9152**.

Advanced practice nurses need a physician's number to obtain vaccines.

5.3.4 Provider Immunization Reimbursement Fee

THSteps and other qualified providers may be reimbursed $5 for each dose of vaccine administered during an THSteps Medical Screen, adolescent screen, or a follow-up visit. Combined antigen vaccines (DTaP-Hib, MMR) are reimbursed as one dose.

5.3.5 Instructions

By enrolling, public and private providers agree to:

1) Sign for each order of vaccine:
   (a) Public health regions and local health departments/districts may be exempt from signing individual vaccine orders
   (b) Biological Order Form (Form C-68) may be used to order vaccine
2) Complete a Summary Sheet For Immunizations (Form C-5) each month for the doses of vaccine administered by age group
3) Complete the Monthly Vaccine Report (Form C-33) each month making certain that monthly wastage and loss of state and federally funded vaccine are in the expla-

nation section of the report (list vaccines by vaccine category, vaccine lot number and vaccination expiration date); excessive waste with no attempt to return short-dated vaccine will be sufficient grounds to terminate this agreement

4) Complete the Monthly Vaccine Inventory by Lot No. (Form C-33-A) each month if required by your regional or local health department

5) Have the patients:

   (a) Read and sign the appropriate **Vaccine Information Statements** (VIS) or

   (b) Read the appropriate VIS and sign the **Vaccine Information Documentation Form** (Form C-100) each time an immunization is to be administered

6) Not charge the patients for vaccines provided by the health department

Display the poster (TDH Form 6-36) where it will be easily seen by the patients (private physicians are not required to display the poster).

5.3.6 Billing Instructions

Routine immunizations administered during a THSteps medical checkup or following visit should be billed using the provider's EPSDT provider number. If administered outside of a THSteps medical checkup or follow-up visit, use the provider's regular Medicaid provider number (P000, Z000). Refer to Section 39, "Texas Health Steps (THSteps)," of the *2000 Texas Medicaid Provider Procedures Manual.*

Use the following immunization procedure codes when billing on the HCFA-1500 claim form.

Diagnosis code V2020 is required to be used with the following procedure codes:

Procedure Code	Description
S-32A0Y	Administration of DTP # I
S-32B0Y	Administration of DTP #2
S-32C0Y	Administration of DTP #3
S-32D0Y	Administration of DTP #4
S-32E0Y	Administration of DTP #5
S-35A0Y	Administration of MMR#1
S-35B0Y	Administration of MMR #2
S-40A0Y	Administration of DTaP #1
S-40B0Y	Administration of DTaP #2
S-41A0Y	Administration of Td #1
S-34A0Y	Administration of DT/Td # I
S-34B0Y	Administration of DT/Td #2
S-34C0Y	Administration of DT/Td #3
S-34D0Y	Administration of DT/Td #4
S-34E0Y	Administration of DT/Td #5
S-38A0Y	HEPT B #1
S-38B0Y	HEPT B #2
S-38C0Y	HEPT B #3
S-33A0Y	Administration of OPV #1
S-33B0Y	Administration of OPV #2
S-33C0Y	Administration of OPV #3
S-33D0Y	Administration of OPV #4 (Do not give before age 4)
S-33E0Y	Administration of OPV #5 (For children off current schedule)
S-36A0Y	Administration of HibCV #1
S-36B0Y	Administration of HibCV #2

Procedure Code	Description
S-36C0Y	Administration of HibCV #3
S-36D0Y	Administration of HibCV #4
S-42A0Y	Administration of DTP/Hib #1
S-42B0Y	Administration of DTP/Hib #2
S-42C0Y	Administration of DTP/Hib #3
S-42D0Y	Administration of DTP/Hib #4
S-43A0Y	Administration of IPV #1
S-43B0Y	Administration of IPV #2
S-43C0Y	Administration of IPV #3
S-43D0Y	Administration of IPV #4
S-5743X	Administration of Varicella
S-5745X	Administration of DTaP #1
S-5746X	Administration of DTaP #2
S-5747X	Administration of DTaP #3
S-5748X	Administration of DTaP #4
S-5749X	Administration of DTaP #5

Immunization Procedure Codes and Diagnosis Code V0690:

Immunization	Procedure Code	Immunization	Procedure Code
OTHER	9-5739X	DTP/Hib #3	9-5734X
DTP #1	9-5701X	DTP/Hib #4	9-5735X
DTP #2	9-5702X	IPV #1	9-5723X
DTP #3	9-5703X	IPV #2	9-5724X
DTP #4	9-5704X	IPV #3	9-5725X
DTP #5	9-5705X	IPV #4	9-5713X
DTaP #1	9-5711X	HibCV #1	9-5716X
DTaP #2	9-5712X	HibCV #2	9-5717X
DT(Child) #1	9-5706X	HibCV #3	9-5718X
DT(Child) #2	9-5707X	HibCV #4	9-5719X
DT(Child) #3	9-5708X	HEPT A	9-5741X
DT(Child)#4	9-5709X	HEPT B #1	9-5729X
DT(Child)#5	9-5710X	HEPT B #2	9-5730X
Td #1	9-5736X	HEPT B #3	9-5731X
OPV #1	9-5720X	MMR #1	9-5726X
OPV #2	9-5721X	MMR #2	9-5727X
OPV #3	9-5722X	Varicella	9-5743X
OPV #4	9-5714X	DtaP #1	9-5745X
OPV #5	9-5715Y	DtaP #2	9-5746X
DTP/Hib #1	9-5732X	DtaP #3	9-5747X
DTP/Hib #2	9-5733X	DtaP #4	9-5748X
		DtaP #5	9-5749X

When billing immunizations on the HCFA-1500 claim form, use the above-listed DTaP, IPV, and Td codes when billing for:

- DTaP vaccine in lieu of DTP vaccine for the 4th and 5th doses in the sequence
- IPV vaccine in lieu of OPV
- Td (Tetanus-Diphtheria Adult) administered to people ages 7 through 20

5.4 Texas Vaccines for Children Program Packet (11 Pages)

Texas Vaccines For Children Program

Questions and Answers

①

Texas Vaccines for Children Program

1. Question: What is the Texas Vaccines for Children Program?

   Answer: This is an expansion of the current immunization initiative that started with Shots Across Texas. Additional federal funds are available to expand vaccine administration and vaccine distribution. Plans are being developed to distribute vaccines directly to physicians in selected areas of Texas.

Children Who Qualify

2. Question: Which children qualify for free vaccines?

   Answer: All children eligible for free vaccines except:
   (1) children with insurance that pays for immunization services, and
   (2) children whose parents or guardians are able to pay for immunization services.

Underinsured Children

3. Question: What about children with insurance that doesn't include vaccination as a covered benefit? Are they eligible to receive free vaccine?

   Answer: Yes, they are eligible.

Vaccine-Related Fees

4. Question: Why are there fee caps on what providers can charge to administer the vaccine?

   Answer: Federal legislation requires fee caps for administration on a statewide basis that balance the provider's financial need and the patient's ability to pay. The fee cap for Texas is $14.85 per vaccine.

Texas Vaccines For Children Program

Questions and Answers

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5. Question: Will the Texas Medicaid Program reimburse private practitioners for vaccines administered to Medicaid patients?

   Answer: Yes. The Texas Medicaid vaccine administration fee is $5.00 per vaccine dose administered.

Medicaid Enrollment

6. Question: To participate in the Texas Vaccines for Children Program, must providers enroll as a state Medicaid provider?

   Answer: No. However, if you are enrolled in the state Medicaid Program, you must register in the Texas Vaccines for Children Program to receive free vaccine.

Why Register?

7. Question: Why should a health care provider enroll in the Texas Vaccines for Children Program?

   Answer: You can get free vaccine for your eligible patients.
   You will not need to refer patients to public clinics for vaccines.
   You can provide immunizations to your patients as part of a comprehensive care package - this will enhance the opportunity for patients to find a medical home.

Patients served

8. Question: Once enrolled, are providers required to immunize children who are not their patients?

   Answer: No. You control who you see in your practice.

Texas Vaccines For Children Program

Questions and Answers

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9. Question: Why must providers complete a Provider Profile describing patients by eligibility category?

   Answer: This information allows the Texas Department of Health to determine how the cost of vaccine will be divided among state and federal funds. Please provide your best estimates. After a year, you may find your profile information has changed. The Provider Profile must be updated annually.

Vaccine Ordering & Supply

10. Question: Can providers choose a specific manufacturer's vaccine and always receive it?

    Answer: No. The Texas Department of Health would like to allow for provider preference, but we will not be able to guarantee first choice on all orders. However, we will try and minimize differences.

11. Question: How will I order vaccines that I need for my eligible patients?

    Answer: Private physicians may call: **1-800-252-9152**.
    Public health departments/districts and providers will continue to order vaccines as they currently do.

12. Question: It is difficult to separate patients who are fully insured from Texas Vaccines for Children Program eligible patients. Why must I order their vaccine separately?

    Answer: Children whose insurance includes immunizations and patients who are able to pay for the vaccines are not eligible to receive free vaccine through the Texas Vaccines For Children Program.

Texas Vaccines For Children Program

Questions and Answers

④

Duty to warn unchanged

13. Question: Will providers be required to increase the amount of Vaccine Information Materials they provide to parents because of the Texas Vaccines for Children Program?

Answer: No. Materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.

Eligibility Status

14. Question: Must providers ask the patient's eligibility status each time the patient comes for the vaccine visit?

Answer: No. Providers need only update eligibility status whenever there is reason to believe a child's eligibility status has changed.

15. Question: How are providers expected to verify responses for vaccine eligibility?

Answer: Providers are not expected to do anything more than ask the parent what the child's eligibility status is and then record the response. The parent can complete the Vaccine Eligibility Screening Form.

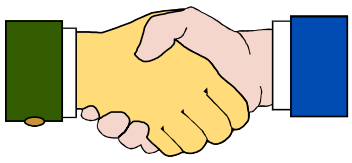
HOW DO I REGISTER?

Registration process

- If you wish to participate in the program and order vaccine; complete the Provider Profile Form and Provider Enrollment Form (enclosed) and return them in the self-addressed, stamped envelope.
- For a group practice, clinic, or hospital, one provider acting as "physician in chief" or equivalent should register and sign on behalf of the group.
- A "Provider Profile", which estimates the number of children seen in your practice annually by "eligibility" category, must be completed. This helps us in estimating vaccine needs and determining appropriate funding for the Texas Vaccines for Children Program.

WHEN I REGISTER, WHAT AM I AGREEING TO DO?

- To screen child's eligibility.
- To retain a record of the Screening Eligibility Form for 3 years.
- To comply with the recommended immunization schedule (enclosed).
- To immunize eligible children at no cost. (An office on-site fee may be charged. Administration fees may be charged so long as they do not exceed the regional fee cap and service is not denied because the fee cannot be paid).
- To provide vaccine information materials to the child's parent or guardian.
- To provide access to records if requested by the Texas Department of Health, the local health authority, or the U.S. Department of Health and Human Services.
- To report on a monthly basis the number of doses of vaccines administered, lost, and wasted.



HOW DO I ORDER VACCINE?

- There is no out of pocket expense for you to order vaccine for eligible children.
- Once registered, call 1-800-252-9152.
- Place your first vaccine order as early as September 1, 1994.
- Allow up to four weeks for delivery.
- Reorder vaccine three to four times annually. (More frequent or fewer orders may be appropriate for your practice.)

CALL 1-800-252-9152

TO ORDER VACCINE

The Texas Vaccines for Children Program will have no impact on your present system of ordering, purchasing, and billing insurance for your fully insured patients.

REQUIREMENTS FOR THE TEXAS VACCINES FOR CHILDREN PROGRAM

INSTRUCTIONS:

The private physician, public health region, local health department/district, community/migrant rural health clinic, or other organization that qualifies for Texas Vaccines for Children Program agrees to:

1. sign for each order of vaccine:

   (a) public health regions and local health departments/districts may be exempt from signing individual vaccine orders.

   (b) Biological Order Form (Form C-68) may be used to order vaccine.

2. complete a Summary Sheet For Immunizations (Form C-5) each month for the doses of vaccine administered by age group.

3. complete the Monthly Vaccine Report (Form C-33) making certain that monthly wastage and loss of state and federally funded vaccines are in the explanation section of the report (vaccines must be listed by vaccine category, vaccine lot number, and vaccination expiration date); excessive waste with no attempt to return short-dated vaccine will be sufficient grounds to terminate this agreement.

4. complete the Monthly Vaccine/Toxoid/Biological Inventory by Lot Number (Form C-33-A) each month if required by your regional or local health department.

5. use Vaccine Information Statements: Public and private clinics should have the patient, parent, guardian, or responsible adult:

   (a) read the appropriate Vaccine Information Statements and sign the consent form each time an immunization is administered, or

   (b) read the appropriate Vaccine Information Statements and sign the Vaccine Information Documentation Form (Form C-100) each time an immunization is administered.

6. comply with the requirements of the National Childhood Vaccine Injury Act.

   The provider must record, either on the patient's permanent medical record, the Vaccine Information Statements, or the Vaccine Information Documentation Form, the information listed below:

   - ✓ date vaccine is administered;
   - ✓ manufacturer's name and lot number of the vaccine;
   - ✓ site of injection;
   - ✓ signature of person administering the vaccine;
   - ✓ professional title of person administering the vaccine; and
   - ✓ address of the facility in which the vaccine is administered.

Revised 9/02/94

Texas Vaccines For Children Program
Patient Eligibility Screening Record

Purpose: To determine eligibility and the source of funds for the Texas Department of Health to be reimbursed for vaccines.

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger, who receive immunization through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: _____

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____/_____/_____

Parent/Guardian
Individual of Record: _____
Last Name First Name MI

Provider's Name: _____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check 1st category that applies):

- ❒ (a) enrolled in Medicaid or
- ❒ (b) does not have health insurance or
- ❒ (c) is an American Indian or
- ❒ (d) is an Alaskan Native or
- ❒ (e) is underinsured (has health insurance that Does Not pay for vaccines) & routinely referred to a Federal Qualified Health Center or Rural Health Clinic for immunizations or
- ❒ (f) is underinsured (has health insurance that Does Not pay for vaccines) & routinely referred to a facility that is not a Federally Qualified Health Center or Rural Health Clinic for immunizations or
- ❒ (g) is a patient who is served by any type of public health clinic and does not meet any of the above criteria

* I agree that the record of vaccines my child gets through this program may be given to school officials, public health officials, authorized government agencies and other public health staff."

_____
(parent/guardian signature)

TEXAS VACCINES FOR CHILDREN PROGRAM: PROVIDER ENROLLMENT

This record is to be submitted to the Texas Department of Health and must be updated in accordance with State policy.

Name of Facility or Clinic: _____

Provider Name: _____
(Last Name) (First Name) (MI) (Title)

Contact: _____
(Last Name) (First Name) (MI) (Title)

Mailing Address: _____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: _____
(Street Address) (Suite Number) (City) (Zip)

Telephone Number: (_____)_____-_____ Fax Number: (_____)_____-_____

Provider Identification Number (Medical License Number): _____

Is your practice/clinic a Federally Qualified Health Center (FQHC)? Check:Yes: ❒ No: ❒

In order to participate in the Texas Vaccines for Children Program and/or to receive federally and state-supplied vaccines provided to me at no cost, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician-in-chief or equivalent, agree to the following:

1. Before administering vaccines obtained through the Texas Vaccines for Children Program, I will ask the child's parent or guardian if the child is eligible. I will use the Patient Eligibility Screening Form to complete this mandatory screening requirement.

2. I will maintain records of the parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for a period of 3 years, unless State requirements call for a longer duration. If requested, I will make such records available to the Texas Department of Health (TDH), the local health department/authority or the U.S. Department of Health and Human Services.

3. I will comply with the appropriate immunization schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgement in accordance with accepted medical practice, I deem such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4. I will provide Vaccine Information Statements to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. (Signatures are required for the Vaccines for Children Program.)

5. I will not charge for vaccines supplied by TDH and administered to a child who is eligible for the Texas Vaccines for Children Program.

6. I may charge a vaccine administration fee. I will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by TDH. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.

7. I will not deny administration of a Texas Vaccines for Children Program vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.

8. I will comply with the State's requirements for ordering vaccine and other requirements as described by TDH.

9. I or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

_____ _____
(Provider Signature) (Date)

TEXAS VACCINES FOR CHILDREN PROGRAM: PROVIDER PROFILE FORM
Public and private TVFC providers must complete the front and back of this form annually, and/or when the clinic type changes (for example a private provider becomes an agent of a Federally Qualified Health Center).
Date: A: Name of Facility or Clinic:
B. Provider Name (Physician-in-charge)
C. Vaccine Shipping Address: (Street Address) (City) (Zip) (County)
D. Phone Number ( ) -
E. Is your facility a Federally Qualified Health Center (Migrant or Rural Health clinic)? (circle one) YES NO
F. Type of Clinic: (✓ check one) ❒ Public Health Department/District ❒ Private Hospital ❒ Public Hospital ❒ Private Practice (Individual or Group) ❒ Other Public Clinic ❒ Other Private Practice
G. PATIENT PROFILE:

	< 1 year old	1-6 years old	7-18 years old	19+ years old	Total
TOTAL PATIENTS: Please enter the number of children who will receive vaccinations at your clinic in 2000					

H: Categories of Children Eligible for Texas Vaccines for Children Program:

Of the total numbers of children entered in Section F, please enter the number of children for each of the following categories by age group:

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1-6 years old	7-18 years old	19+ years old	Total
a. Number Enrolled in Medicaid					
b. Number That Do Not Have Health Insurance					
c. Number of American Indians					
d. Number of Alaskan Natives					
e. Underinsured					
f. Children who do not meet any of the above criteria, but still receive immunizations at public health clinics					

Please list all providers within the practice participating in the TVFC

LAST NAME	FIRST NAME	MIDDLE INITIAL	TITLE	MEDICAL LICENSE NUMBER	MEDICAID PROVIDER NUMBER	SPECIALTY

6

HIV AIDS

HIV/AIDS Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

HIV/AIDS Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

6.1 HIV/STD Policy Minimum Standards and Guidelines

6.1.1 Purpose

To protect employment rights and privileges of individuals infected with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs which address HIV/AIDS in the workplace. The Texas Department of Health (TDH) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients. However, the content and intent must remain consistent with this document and the Texas Health and Safety Code.

6.1.2 Authority

Governance for this policy is found in Vernon's Texas Codes Annotated, Health & Safety Code (HSC), §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines developed by the TDH, Bureau of HIV and STD Prevention, as required by HSC, §85.012, "Model Workplace Guidelines"; and adopted as HIV/STD Policy No. 020.006, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of 10 designated state agencies and organizations funded by the 10 designated state agencies. Refer to "State Agencies Listed Under HSC §85.113" on page 6-6. These guidelines are also the standard for health care facilities licensed by TDH, the Texas Department of Mental Health and Mental Retardation, and the Texas Department of Human Services, as stated in HSC 85.113, "Workplace Guidelines for State Contractors."

6.1.3 Who Must Use Workplace Guidelines

6.1.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the TDH model workplace guidelines in this policy.

6.1.3.2 State Contractors

A program involving direct client contact, which contracts with or is funded by any of the state agencies listed in "State Agencies Listed Under HSC §85.113" on page 6-6, will adopt and carry out workplace guidelines as stated in HSC, §85.113.

6.1.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to co-workers through ordinary workplace contact;

- Provide workers with current information about HIV risk reduction for employees and their families;
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues;
- Prevent work disruption and rejection of the infected employee by co-workers;
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety;
- Provide specific and ongoing education and equipment to employees in health care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used; and
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

6.1.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. We encourage use of the following statements in agency policy.

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities.

- A. **Discrimination**. The *Americans with Disabilities Act* (ADA) of 1990 prohibits discrimination against people with disabilities, which include HIV and AIDS, in employment, public accommodations, public transportation, and other situations. A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the ADA protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.
- B. **Desire and Ability to Work**. A workplace policy should address the infected employee's desire and need to work, and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them. The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation.
- C. **Performance Standards**. The ADA provides protections for disabled persons "qualified" to perform his or her job. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job with or without the reasonable accom-

modation. One suggested statement is, "While the ADA does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."

- D. **Reasonable Accommodation**. The ADA requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the ADA. Such a policy statement might read, "The following options may be considered for people with HIV/AIDS:
  - Possible assignment or reassignment of job duties,
  - Working at home,
  - Leaves of absence, and
  - Flexible work schedules."
- E. **Confidentiality and Privacy**. Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds. Employees are not required to reveal their HIV status to employers. All medical information that an HIV infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty"). A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."
- F. **Co-worker Concerns**. Employers need to be aware of the concerns that co-workers may have about an HIV infected co-worker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to co-worker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."
- G. **Employee Education**. Any health care facility **licensed by** the TDH, the Texas Department of Mental Health and Mental Retardation, or the Texas Department of Human Services must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," TDH developed model education program guidelines. These are available from TDH, HIV/STD Health Resources Division, 1100 W. 49th St., Austin, Tx. 78756, (512) 490-2525. Employers may also find the CDC's educational kit, *Business Responds to AIDS*, useful in developing educational courses. The kit is available at the address given on page 5 of this policy. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and co-workers. Experience shows that educated co-workers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions. Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids which are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are

physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.

- H. **Assistance**. Some employers have designated benefits programs available to employees and family members with HIV infection. Employers who have no employee assistance program may consider working with other organizations which provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services,
  - Provide HIV/AIDS workplace training for managerial staff,
  - Serve as a liaison between management and the employer's clinical and occupational health programs, and
  - Provide counseling for employees who irrationally fear co-workers or clients.
- A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues:
  - Education and information concerning HIV/AIDS;
  - Confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and
  - Benefits consultation to help employees effectively manage health, leave, and other benefits."

6.1.6 Where To Go For Help

Refer employees to the Texas HIV/STD InfoLine, 800-299-AIDS or other appropriate resource. This is a toll-free HIV/AIDS and STD information and referral service sponsored by TDH. It provides referrals to HIV/AIDS testing sites; prevention, case management and treatment providers; STD clinics; and other related service organizations. Information and referral is available for English and Spanish speaking callers, and for those who are hearing impaired.

For additional guidance, please consult the CDC's *Business Responds to AIDS Manager's Kit*. This kit includes a large section on workplace policies with information on the ADA, small businesses, health insurance, Social Security Disability Insurance, and Supplemental Security Income (CDC National Aids Clearinghouse BRTA Resource Service, P.O. Box 6003, Rockville, MD. 20849-6003, 800-458-5231). The CDC National AIDS Hotline is a 24-hour toll-free service providing referrals and free educational materials to the public regarding AIDS transmission, prevention, risk reduction, testing, symptoms, and other related issues. Call 800-342-AIDS for information in English, 800-344-7432 for information in Spanish, and 800-243-7889 for hearing impaired information about AIDS.

6.1.7 State Agencies Listed Under HSC §85.113

The HSC, 85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by any of the following state agencies to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." These agencies are following.

- Texas Commission on Alcohol and Drug Abuse
- Texas Commission for the Blind

- Texas Commission for the Deaf and Hearing Impaired
- Texas Department of Criminal Justice
- Texas Department of Health
- Texas Department of Human Services
- Texas Department of Mental Health and Mental Retardation
- Texas Juvenile Probation Commission
- Texas Rehabilitation Commission
- Texas Youth Commission

6.2 Health and Safety Code (Chapter 85) and Chapter 98 of the Texas Administrative Code, Title 25

The following are sections applicable to TDH relating to HIV workplace guidelines.

6.2.1 V.T.C.A. Health and Safety Code §§85.003-85.009 (25TAC §97.142 Model Health Education Program/Resource Guide for HIV/AIDS Education of School-age Children)

6.2.1.1 Sec. 85.003. Department as Lead Agency and Primary Resource.

The department, in the discharge of its duty to protect the public health, shall act as the lead agency for AIDS and HIV policy for Texas and is the primary resource for HIV education, prevention, risk reduction materials, policies, and information in this state. Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991. Amended by Acts 1993, 73rd Leg., ch. 708, Sec. 2, eff. Sept. 1,1993.

6.2.1.2 Sec. 85.004. Education Programs.

- (a) The department shall develop model education programs to be available to educate the public about AIDS and HIV infection.
- (b) As part of the programs, the department shall develop a model educational pamphlet about methods of transmission and prevention of HIV infection, about state laws relating to the transmission, and to conduct that may result in the transmission of HIV.
- (c) The programs must be scientifically accurate and factually correct and designed to:
  - (1) communicate to the public knowledge about methods of transmission and prevention of HIV infection;
  - (2) educate the public about transmission risks in social, employment, and educational situations;
  - (3) educate health care workers and health facility employees about methods of transmission and prevention in their particular workplace environments; and
  - (4) educate the public about state laws relating to the transmission and conduct that may result in the transmission of HIV.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.1.3 Sec. 85.005. Special Components of Education Programs.

- (a) The department shall include in the education programs special components designed to reach:
  - (1) persons with behavior conducive to HIV transmission;
  - (2) persons younger than 18 years of age; and
  - (3) minority groups.

- (b) In designing education programs for ethnic minorities and in assisting local community organizations in developing education programs for minority groups, the department shall ensure that the programs reflect the nature and spread of HIV infection in minorities in this state.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.1.4 Sec. 85.006. Education Programs for Disabled Persons.

- (a) The department shall develop and promote HIV education and prevention programs specifically designed to address the concerns of persons with physical or mental disabilities.
- (b) In designing those programs, the department shall consult persons with disabilities or consult experts in the appropriate professional disciplines.
- (c) To the maximum extent possible, state-funded HIV education and prevention programs shall be accessible to persons with physical disabilities.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.1.5 Sec. 85.007. Education Programs for Minors.

- (a) The department shall give priority to developing model education programs for persons younger than 18 years of age.
- (b) The materials in the education programs intended for persons younger than 18 years of age must:
  - (1) emphasize sexual abstinence before marriage and fidelity in marriage as the expected standard in terms of public health and the most effective ways to prevent HIV infection, sexually transmitted diseases, and unwanted pregnancies; and
  - (2) state that homosexual conduct is not an acceptable lifestyle and is a criminal offense under Section 21.06, Penal Code.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.1.6 Sec. 85.008. Distribution of Education Programs.

- (a) The department shall determine where HIV education efforts are needed in this state and shall initiate programs in those areas by identifying local resources.
- (b) The department shall assist communities, especially those in rural areas, in establishing self-sustaining education programs, using public and private resources.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.1.7 Sec. 85.009. Education Programs Available on Request.

The department shall make the education programs available to local governments and private businesses on request. Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.2 V.T.C.A. Health and Safety Code §85.012. Model Workplace Guidelines (25TAC §97.143 Model HIV/AIDS Workplace Guidelines)

6.2.2.1 Sec. 85.012. Model Workplace Guidelines.

- (a) To ensure consistent public policy, the department, in consultation with appropriate state and local agencies and private entities, shall develop model workplace guidelines concerning persons with HIV infection and related conditions.
- (b) The model workplace guidelines must include provisions stating that:
  - (1) all employees will receive some education about methods of transmission and prevention of HIV infection and related conditions;
  - (2) accommodations will be made to keep persons with HIV infection employed and productive for as long as possible;

- (3) the confidentiality of employee medical records will be protected;
- (4) HIV-related policies will be consistent with current information from public health authorities, such as the Centers for Disease Control of the United States Public Health Service, and with state and federal law and regulations;
- (5) persons with HIV infection are entitled to the same rights and opportunities as persons with other communicable diseases; and
- (6) employers and employees should not engage in discrimination against persons with HIV infection unless based on accurate scientific information.

- (c) The department shall develop more specific model workplace guidelines for employers in businesses with educational, correctional, health, or social service responsibilities.
- (d) The department shall make the model workplace guidelines available on request.
- (e) Employers should be encouraged to adopt HIV-related workplace guidelines that incorporate, at a minimum, the guidelines established by the board under this section.
- (f) This chapter does not create a new cause of action for a violation of workplace guidelines.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.3 V.T.C.A. Health and Safety Code, Subchapter E. Duties of State Agencies and State Contractors, §85.111. Education of State Employees

6.2.3.1 Sec. 85.011. Contracts for Education Programs.

- (a) The department may contract with any person, other than a person who advocates or promotes conduct that violates state law, for the design, development, and distribution of education programs.
- (b) This section does not restrict an education program from providing accurate information about different ways to reduce the risk of exposure to or the transmission of HIV.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.4 V.T.C.A. Health and Safety Code §85.114. Education of Certain Clients, Inmates, Patients, and Residents

6.2.4.1 Sec. 85.114. Education of Certain Clients, Inmates, Patients, and Residents.

- (a) Each state agency listed in Section 85.113 shall routinely make available HIV education for clients, inmates, patients, and residents of treatment, educational, correctional, or residential facilities under the agency's jurisdiction.
- (b) Education available under this section shall be based on the model education program developed by the department and tailored to the cultural, educational, language, and developmental needs of the clients, inmates, patients, or residents, including the use of Braille or telecommunication devices for the deaf.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.5 V.T.C.A. Health and Safety Code §85.112. Workplace Guidelines and §85.113. Workplace Guidelines for State Contractors.

6.2.5.1 Sec. 85.112. Workplace Guidelines.

- (a) Each state agency shall adopt and implement workplace guidelines concerning persons with AIDS and HIV infection.

- (b) The workplace guidelines shall incorporate at a minimum the model workplace guidelines developed by the department.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.5.2 Sec. 85.113. Workplace Guidelines for State Contractors.

An entity that contracts with or is funded by any of the following state agencies to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity:

- (1) the Texas Commission on Alcohol and Drug Abuse;
- (2) the Texas Commission for the Blind;
- (3) the Texas Commission for the Deaf and Hard of Hearing;
- (4) the Texas Juvenile Probation Commission;
- (5) the Texas Department of Criminal Justice;
- (6) the Texas Youth Commission;
- (7) the department;
- (8) the Texas Department of Human Services;
- (9) the Texas Department of Mental Health and Mental Retardation; and
- (10) the Texas Rehabilitation Commission.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991. Amended by Acts 1995, 74th Leg., ch. 835, Sec. 25, eff. Sept. 1, 1995.

6.2.6 V.T.C.A. Health and Safety Code §85.115. Confidentiality Guidelines.

6.2.6.1 Sec. 85.115. Confidentiality Guidelines.

- (a) Each state agency shall develop and implement guidelines regarding confidentiality of AIDS and HIV-related medical information for employees of the agency and for clients, inmates, patients, and residents served by the agency.
- (b) Each entity that receives funds from a state agency for residential or direct client services or programs shall develop and implement guidelines regarding confidentiality of AIDS and HIV-related medical information for employees of the entity and for clients, inmates, patients, and residents served by the entity.
- (c) The confidentiality guidelines shall be consistent with guidelines published by the department and with state and federal law and regulations.
- (d) An entity that does not adopt confidentiality guidelines as required by Subsection (b) is not eligible to receive state funds until the guidelines are developed and implemented.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.7 V.T.C.A. Health and Safety Code §85.116. Testing and Counseling for State Employees Exposed to HIV Infection on the Job [25TAC §97.140. Counseling and Testing for State Employees Exposed to Human Immunodeficiency Virus (HIV) Infection on the Job]

6.2.7.1 Sec. 85.116. Testing and Counseling for State Employees Exposed to HIV Infection on the Job.

- (a) On an employee's request, a state agency shall pay the costs of testing and counseling an employee of that agency concerning HIV infection if:
  - (1) the employee documents to the agency's satisfaction that the employee may have been exposed to HIV while performing duties of employment with that agency; and

- (2) the employee was exposed to HIV in a manner that the United States Public Health Service has determined is capable of transmitting HIV.

- (b) The board by rule shall prescribe the criteria that constitute possible exposure to HIV under this section. The criteria must be based on activities the United States Public Health Service determines pose a risk of HIV infection.
- (c) For the purpose of qualifying for workers' compensation or any other similar benefits or compensation, an employee who claims a possible work-related exposure to HIV infection must provide the employer with a written statement of the date and circumstances of the exposure and document that, within 10 days after the date of the exposure, the employee had a test result that indicated an absence of HIV infection.
- (d) The cost of a state employee's testing and counseling shall be paid from funds appropriated for payment of workers' compensation benefits to state employees. The director of the workers' compensation division of the attorney general's office shall adopt rules necessary to administer this subsection.
- (e) Counseling or a test conducted under this section must conform to the model protocol on HIV counseling and testing prescribed by the department.
- (f) A state employee who may have been exposed to HIV while performing duties of state employment may not be required to be tested.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.8 V.T.C.A. Health and Safety Code §85.010. Educational Course for Employees and Clients of Health Care Facilities

6.2.8.1 Sec. 85.010. Educational Course for Employees and Clients of Health Care Facilities.

A health care facility licensed by the department, the Texas Department of Mental Health and Mental Retardation, or the Texas Department of Human Services shall require its employees to complete an educational course about HIV infection based on the model education programs developed by the department. Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.2.9 V.T.C.A. Health and Safety Code §85.116. Testing and Counseling for State Employees Exposed to HIV Infection on the Job (c)

6.2.9.1 Sec. 85.116. Testing and Counseling for State Employees Exposed to HIV Infection on the Job.

- (a) On an employee's request, a state agency shall pay the costs of testing and counseling an employee of that agency concerning HIV infection if:
  - (1) the employee documents to the agency's satisfaction that the employee may have been exposed to HIV while performing duties of employment with that agency; and
  - (2) the employee was exposed to HIV in a manner that the United States Public Health Service has determined is capable of transmitting HIV.
- (b) The board by rule shall prescribe the criteria that constitute possible exposure to HIV under this section. The criteria must be based on activities the United States Public Health Service determines pose a risk of HIV infection.
- (c) For the purpose of qualifying for workers' compensation or any other similar benefits or compensation, an employee who claims a possible work-related exposure to HIV infection must provide the employer with a written statement of the date and circumstances of the exposure and document that, within 10 days after the date of the exposure, the employee had a test result that indicated an absence of HIV infection.

- (d) The cost of a state employee's testing and counseling shall be paid from funds appropriated for payment of workers' compensation benefits to state employees. The director of the workers' compensation division of the attorney general's office shall adopt rules necessary to administer this subsection.
- (e) Counseling or a test conducted under this section must conform to the model protocol on HIV counseling and testing prescribed by the department.
- (f) A state employee who may have been exposed to HIV while performing duties of state employment may not be required to be tested.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 36, eff. Sept. 1, 1991.

6.3 THSteps Medical Checkups Periodicity Schedule

The THSteps Medical Checkups Periodicity Schedule appears on "THSteps Medical Checkups Periodicity Schedule" on page 3-9.

7

THSteps Guidelines and Forms

THSteps Guidelines and Forms

7.1 Child Health Clinical Records

TDH has developed a new child health clinical record. The record is available for use by public and private providers concerning Medicaid and clients potentially eligible for Medicaid. The purpose of the record is to facilitate documentation of all components of a THSteps Medical Screen/Checkup in a standardized format. The child health clinical record was developed by a team of pediatricians and nurses and was field-tested in a variety of settings. Use of this form is optional.

A copy of the Child Health Record's history and preventive health forms are available beginning on page 7-4. These forms are designed to assist you in performing THSteps checkups.

We encourage you to review these forms for use in your office. If you would like a supply of forms, you may order them by writing the TDH Warehouse, Attn.: Literature and Forms Division, 1100 W. 49th Street, Austin, Texas 78756-3168. Please use the stock number on the bottom of each page when ordering. Refer to the following table for a listing of all forms and stock numbers. You may also request a camera ready copy or a diskette for printing forms CH-1 through CH-8 in your office. Agencies requesting more than 300 copies of any one form may be given a camera ready copy or diskette rather than actual forms.

Stock Numbers	
CH-1	Child Health History
CH-2	Preventive Health Visit - Birth To 1 Month
CH-3	Preventive Health Visit - 2-6 Months
CH-4	Preventive Health Visit - 7-12 Months
CH-5	Preventive Health Visit - 13 Months To 2 Years
CH-6	Preventive Health Visit - 3-5 Years
CH-7	Preventive Health Visit - 6-10 Years
CH-8	Preventive Health Visit - 10-20 Years
CH-9	Growth Chart - Infant Girl
CH-10	Growth Chart - Infant Boy
CH-11	Growth Chart - Child Girl
CH-12	Growth Chart - Child Boy
WIC-42	24-Hour Dietary Recall And Assessment For Infants - Birth Through 11 Months
*	24-Hour Dietary Recall And Assessment For Children - 1 Through 4 Years
CH-14	24-Hour Dietary Recall And Assessment For Children - 5 Through 9 Years
CH-15	24-Hour Dietary Recall And Assessment For Teens - 10 Through 20 Years (Non-Pregnant Teens)

* Can be obtained from any Public Health Nutrition Program

7.2 Child Health History (2 Pages)

CHILD HEALTH HISTORY

TEXAS DEPARTMENT OF HEALTH

NAME:_____
DOB:___/___/___ SEX:_____
SSN/RECORD #:_____
RACE/ETHNICITY:_____
Medical Home:_____
Age:_____
Informant/Relationship:_____

PREGNANCY & BIRTH

G__ P__ AB __ Total number of living children____ Weight Gain/Loss____ Mother's age at birth____
Number of years between previous pregnancy and this child_____ Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider_____ Vitamins: __ Yes No Iron: Yes No If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: Yes No (If yes, proceed with CHILD'S MEDICAL HISTORY)

Maternal Complications:	Maternal Substance Use:	Birth/Delivery:
_ Dental disease _ Vaginal bleeding _ Hypertension _ Premature labor _ Flu-like illness or high temperature _ Kidney or bladder infection _ Anemia _ Diabetes STDs Injury/Hospitalization/Surgery _ Rh negative _ Exposure to TB _ Exposure to lead, chemicals	OTC meds _____ Prescription meds _____ Tobacco _____ _ Alcohol _____ _ Street Drugs _____ _ Caffeine _____ + = positive findings - = negative findings	Place of Birth _____ Birth Attendant _____ Hours of Labor _____ Term ___ Premature (Weeks) ___ More than 2 weeks overdue Type of delivery: ___ Vaginal ___ C-section __ Forceps Complications: ___ Breech ___ Multiple birth __ Other

Explanation/Other:

NURSERY COURSE: Birth Weight ____ Birth Length____ FOC____

Difficulty w/ initial breathing
Heart murmur
_ Infection
_ Transfusion
_ Jaundice req. treatment
_ Seizures

Age at discharge:____ ICN____days Newborn screening (date/location) 1) _____ 2) _____
Comments

CHILD'S MEDICAL HISTORY Immunizations current _ Yes _ No _ Record unavailable
Dental care/sealants current: _ Yes _ No

_ Trauma/Injuries Hospitalizations
_ Surgery
_ Medications
_ Anemia
_ Early childhood caries
_ Hepatitis
Strep throat
Ear infections
_ Bladder/Kidney Infections
_ Pneumonia
_ Developmental delays
_ Vision problems
_ Hearing problems
_ Seizures
_ Environmental toxin exposure (lead, etc)
_ Allergies
_ Asthma
_ Eczema
_ Substance use (alcohol, drug, tobacco)
_ Other

Explanation:

FAMILY MEDICAL HISTORY *(abbreviations for relatives, see back of form)*

_ Anemia/Blood disorder
_ Heart disease before age 50
Cholesterol req. treatment
Hypertension/Stroke
_ Asthma/Allergy
_ Cancer
_ Diabetes
_ Epilepsy/Seizures
_ Kidney problems
_ Muscle/Bone disease
_ Genetic disease or major birth defects
_ Childhood hearing impairment
Tuberculosis
Y = HIV - individual in household (do not identify)
_ Other immunosuppression
_ Dental decay
_ Alcohol/drug abuse
_ Tobacco use
_ Learning disorder
_ Mental retardation
Psychiatric disorder
_ Physical/Sexual/Emotional Abuse
_ Domestic violence
_ Other

Explanation of positive history:

Date:_____ Signature/Title _____ Signature/Title:_____ rev 7-11-02/96

If used for documentation:
Patient's Name _____
Date _____

KEY ELEMENTS

FAMILY MEDICAL HISTORY (abbreviations for relatives)

M - Mother	MGM - Maternal Grandmother	PGM - Paternal Grandmother
F - Father	MGF - Maternal Grandfather	PGF - Paternal Grandfather
S - Sibling	MA - Maternal Aunt	PA - Paternal Aunt
	MU - Maternal Uncle	PU - Paternal Uncle

PROGRESS NOTES

7.3 Child Health Record (Birth to 1 Month) (2 pages)

BIRTH TO 1 MONTH
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
Age _____ **PREVENTIVE HEALTH VISIT**
Informant/Relationship: ______

NAME ______
DOB ______ SEX ______
SSN/RECORD #: ______
RACE/ETHNICITY: ______
Medical Home ______

FAMILY PROFILE AND HEALTH _ No change in household since last visit
Child lives with ___Mother ___Father ___Stepparent ___Grandparent Other Total adults living in home ______
Total children living in home: ____ Primary caretaker for this child: ______ Relationship: ______
Family's concerns/problems:

NUTRITION *Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems _ Y _ N
Breast-fed: Number of feedings in last 24 hours ____ Length of feedings: ___ WIC _ Y _ N
Formula-fed: Type: ______ Iron fortified _ Y _ N Ounces consumed in 24 hours ____ Fluoride _ Y _ N
Solid foods introduced-Age:
* If answered yes, further assessment needed

DEVELOPMENT Parent's concerns:

Standardized Parent Questionnaire: _ P _ F _ Not Done**
Standardized Observational Screen: _ P _ F _ Not Done**
Further assessment needed _ Yes _ No
*** Document reason if neither screen was completed*

Mental Health (see key elements):

SENSORY

Vision screen: _ Normal _ Abnormal

Hearing screen: _ Normal _ Abnormal
Screen used: _ ABR
_ OAE
_ TDH Hearing Checklist

CHILD'S HEALTH Does the systems review note any problems or parent concerns: _ Yes _ No Explain:

Major illness, injury, hospitalization, surgery (When, describe):

Allergies:
Medications taken regularly: Type/Reason:

PHYSICAL EXAMINATION

Temp ______ Pulse ______ Resp ______
FOC ______ Height ______ Weight ______
(%) ______ (%) ______ (%) ______

N A NE
☐ ☐ ☐ Appearance
☐ ☐ ☐ Head/fontanels
☐ ☐ ☐ Skin/nodes
☐ ☐ ☐ Eyes (RR)
☐ ☐ ☐ Ears
☐ ☐ ☐ Nose
☐ ☐ ☐ Mouth/throat
☐ ☐ ☐ Teeth
☐ ☐ ☐ Neck
☐ ☐ ☐ Chest/breasts
☐ ☐ ☐ Heart/pulses
☐ ☐ ☐ Lungs
☐ ☐ ☐ Abdomen
☐ ☐ ☐ Genitalia/Anus
☐ ☐ ☐ Spine/hips
☐ ☐ ☐ Extremities
Neurologic
☐ ☐ ☐ Muscle tone
☐ ☐ ☐ DTRs
☐ ☐ ☐ Primitive reflexes
Explain Abnormalities:

HEALTH EDUCATION

INJURY PREVENTION
_ Car safety restraints
_ Crib safety
_ Burns
_ Falls
_ Drowning/bath safety
_ SIDS
_ Sleep position (SIDS)
_ Passive smoking

BEHAVIOR
_ Crying, colic
_ Sleeping
_ Infant temperament

NUTRITION
_ Breastfeeding
_ No solids until 4 months

HEALTH PROMOTION
_ Care of skin, genitals and cord, circumcision
_ Family planning
_ Well-child care
_ When to call doctor
_ Formula preparation
_ Infant held for bottle
_ No bottle in bed

ASSESSMENT

PLAN

_ WIC _ Referred _ Refused _ N/A
Immunizations _ Up to date _ To be given today _ Deferred (Explain)
Newborn screening _ Up to date _ To be done today
Next appointment:

Date ______ Signature/Title ______ ______ ______ Signature/Title ______

If used for documentation.
Patient's Name: _____
Date: _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, infections, jaundice, cyanosis
Ears: Hearing or ear problems
Eyes: Eye discharge, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardiorespiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, circumcision, number of wet diapers
Neuromuscular: Seizures, sucking reflex, swallowing
Musculoskeletal: Range of motion

MENTAL HEALTH

The mental health assessment for this age also includes the developmental assessment, and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

DEVELOPMENT

Eye contact | Startles to loud noise | Equal movement of limbs | Lifts head

PROGRESS NOTES

7.4 Child Health Record (2 to 6 Months) (2 pages)

2-6 MONTHS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
PREVENTIVE HEALTH VISIT

Age: ____
Informant/Relationship _____

NAME: __ _____
DOB: ____ SEX _____
SSN/RECORD #: __ _____
RACE/ETHNICITY _____
Medical Home _____

FAMILY PROFILE AND HEALTH No change in household since last visit

Child lives with ___Mother ___Father ___Stepparent ___Grandparent ___Other Total adults living in home _____
Total children living in home: ___ Primary caretaker for this child _____ Relationship _
Family's concerns/problems

NUTRITION *Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems: _ Y _ N
Breast-fed. Number of feedings in last 24 hours _____ Length of feedings: WIC. _ Y _ N
Formula-fed: Type: _____ Iron fortified _ Y _ N Ounces consumed in 24 hours. ____ Fluoride _ Y _ N
Solid foods introduced/age:
** If answered yes, further assessment needed*

DEVELOPMENT Parent's concerns

Standardized Parent Questionnaire: _ P _ F _ Not Done**
Standardized Observational Screen: _ P _ F _ Not Done**
Further assessment needed: _ Yes _ No
*** Document reason if another screen was completed.*

Mental Health (see key elements)

SENSORY

Vision screen: Normal _ Abnormal

Hearing screen _ Normal Abnormal
Screen used: _ ABR
_ OAE
_ TDH Hearing Checklist

CHILD'S HEALTH Does the systems review raise any problems or parent concerns. __ Yes __ No Explain:

Major illness, injury, hospitalization, surgery (since last visit).

Allergies:
Medications taken regularly. Type/Reason:

PHYSICAL EXAMINATION Hct/Hgb____ lead___

Temp _____ Pulse _____ Resp _____
HC _____ Height _____ Weight _____
BP _____ %ile _____ %ile _____

N A NE
□ □ □ Appearance
□ □ □ Head/fontanels
□ □ □ Skin/nodes
□ □ □ Eyes (RR)
□ □ □ Ears
□ □ □ Nose
□ □ □ Mouth/throat
□ □ □ Teeth
□ □ □ Neck
□ □ □ Chest/breasts
□ □ □ Heart/pulses
□ □ □ Lungs
□ □ □ Abdomen
□ □ □ Genitalia/Anus
□ □ □ Spine/hips
□ □ □ Extremities
Neurologic:
□ □ □ Muscle tone
□ □ □ DTRs
□ □ □ Primitive reflexes
Explain Abnormalities.

HEALTH EDUCATION

INJURY PREVENTION
_ Car safety restraints
_ Falls/infant walker
_ Burns
_ Choking management
_ Sleep position/SIDS/
Passive smoking
Pool/Bath safety

BEHAVIOR
_ Parent/infant interaction
Sleep
Inappropriate expectations
_ Discipline/baby-sitters

NUTRITION
Breastfeeding
_ Formula preparation
_ Introduction of solids until 4 months

HEALTH PROMOTION
_ Immunizations
_ Thermometer use
_ Dental
_ Teething, wipe teeth
When to call doctor
_ Well-child care
_ Family planning

ASSESSMENT

PLAN

WIC: _ Referred _ Refused _ N/A
Newborn Screening: _ Up-to-date _ To be completed
Immunizations: Up-to-date _ To be given today _ Deferred Explain:
Next appointment:

Date _____ Signature/Title: _____ Signature/Title: ____ _____

If used for documentation:
Patient's Name: _____
Date: _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, Infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardiorespiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, number of wet diapers
Neuro: Seizures, coordinated movements
Musculoskeletal: Fractures, range of motion

MENTAL HEALTH

The mental health assessment for this age also includes the developmental assessment, and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

DEVELOPMENT

2 Months	4 Months	6 Months
Smiles responsively	Looks for source of sound	Reaches for objects
Inspects surroundings	Hands together	Responds to own name
Vocalizes in play	Vocalizes to show displeasure	Vocal imitation, imitates speech sounds
Lifts head	Head steady in supported position	Rolls over

PROGRESS NOTES

7.5 Child Health Record (7 to 12 Months) (2 pages)

7-12 MONTHS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
PREVENTIVE HEALTH VISIT

Age:___
Informant/Relationship:_____

NAME ___ _____ _____
DOB:_____ SEX:_____
SSN RECORD # _ __ _____
RACE/ETHNICITY _____ _
Medical Home:_____

FAMILY PROFILE AND HEALTH _ No change in household since last visit

Child lives with: ___Mother ___Father ___Stepparent ___Grandparent ___Other Total adults living in home:___.
Total children living in home: ____ Primary caretaker for this child. _ _ Relationship: _____
Family's concerns/problems

NUTRITION *Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems _ Y _ N
Breast fed: Number of feedings in last 24 hours. ____ Length of feedings: _____ WIC _ Y _ N
Formula fed: Type: _____ Iron fortified _ Y _ N Ounces consumed in 24 hours. ____ Fluoride: _ Y _ N
Solid foods introduced/Age
* If answered yes, further assessment needed

DEVELOPMENT Parent's concerns:

Standardized Parent Questionnaire: _ P _ F _ Not Done**
Standardized Observational Screen _ P _ F _ Not Done**
Further assessment needed: _ Yes _ No
** *Document reason if neither screen was completed*

Mental Health (see key elements)

SENSORY

Vision screen: _ Normal _ Abnormal

Hearing screen _ Normal _ Abnormal
Screen used: _ ABR
_ OAE
_ TDH Hearing Checklist

CHILD'S HEALTH Does the systems review note any problems or parent concerns: _ Yes No Explain

Major illness, injury, hospitalization, surgery (since last visit):

Allergies:
Medications taken regularly: Type/Reason:

PHYSICAL EXAMINATION hct-hgb____ head____

Temp_____ Pulse _____ Resp _____
FOC _____ Height _____ Weight _____
(%) _____ (%) (%) _____

N A NE
☐ ☐ ☐ Appearance
☐ ☐ ☐ Head/fontanels
☐ ☐ ☐ Skin/nodes
☐ ☐ ☐ Eyes
☐ ☐ ☐ Ears
☐ ☐ ☐ Nose
☐ ☐ ☐ Mouth/throat
☐ ☐ ☐ Teeth
☐ ☐ ☐ Neck
☐ ☐ ☐ Chest/breasts
☐ ☐ ☐ Heart/pulses
☐ ☐ ☐ Lungs
☐ ☐ ☐ Abdomen
☐ ☐ ☐ Genitalia/Anus
☐ ☐ ☐ Spine/hips
☐ ☐ ☐ Extremities
Neurologic:
☐ ☐ ☐ Muscle tone
☐ ☐ ☐ DTRs
Explain Abnormalities.

HEALTH EDUCATION

INJURY PREVENTION	BEHAVIOR	HEALTH PROMOTION
_ Car safety restraints	_ Parent/infant interactive experiences	_ Injury prevention
_ Fall/burns, guns/	_ Speech dev	_ Teething
_ Choking management	_ Sleep	_ Cleaning teeth
_ Water safety/temp	_ Separation anxiety	_ When to call doctor
_ Poisoning	_ Day care	_ Well child care
Child proofing	NUTRITION	Dental appointment
_ Passive smoking	_ Introduction of solids	_ Family planning
_ Breastfeeding support		_ No Smoke in Bed Campaign by 1 year

ASSESSMENT

PLAN

Lab: _ Yes _ No
Hemoglobin/Hematocrit _ Yes _ Not Due _ Refused _ N/A
Immunizations _ Up to date _ To be given today _ Deferred Explain
Next appointment:

Date: __ Signature/Title:_____ _ Signature/Title:_____ _

If used for documentation:
Patient's Name: _____
Date: _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, Infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement: frequency, problems/concerns
Genitourinary: (Male) Normal stream
Neuro: Seizures, coordination
Musculoskeletal: Fractures

MENTAL HEALTH

The mental health assessment for this age also includes the developmental assessment, and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect: physical, sexual or emotional abuse, prenatal substance abuse

DEVELOPMENT

9 Months
Feeds self
Passes object hand to hand
Looks around to find new sounds
Makes long strings of sounds
Stands, holding on

12 Months
Plays appropriately with toys (bugs doll)
Bangs two objects together
Uses one or two verbal labels for objects or people
Stands alone 2 seconds

PROGRESS NOTES

7.6 Child Health Record (13 Months to 2 Years) (2 pages)

13 MONTHS - 2 YEARS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
Age _____ **PREVENTIVE HEALTH VISIT**
Informant-Relationship: _____

NAME: _____
DOB: ___/___/___ SEX: ___
SSN/RECORD # _____
RACE/ETHNICITY: _____
Medical Home _____

FAMILY PROFILE AND HEALTH _ No change in household since last visit

Child lives with: Mother ___Father ___Stepparent ___Grandparent ___Other Total adults living in home: _____
Total children living in home: Primary caretaker for this child: Relationship: ___
Family's concerns/problems

NUTRITION *Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental _ Y _ N

Usual Servings Per Day: __ Dairy __ Formula __ Breast __ Vegetables WIC _ Y _ N
__ Breads, cereal, rice and pasta Meat, poultry, fish, eggs and dry beans Fruits Fluoride _ Y _ N
* If answered yes, further assessment needed

DEVELOPMENT Parent's concerns:

Standardized Parent Questionnaire: _ P _ F _ Not Done**
Standardized Observational Screen _ P _ F _ Not Done**
Further assessment needed: _ Yes _ No
** *Document reason if neither screen was completed.*

Mental Health (see key elements)

SENSORY

Vision screen: _ Normal _ Abnormal

Hearing screen: _ Normal Abnormal
Screen Used: _ ABR
_ OAE
_ TDH Hearing Checklist

CHILD'S HEALTH Does the systems review note any problems or parent concerns: _ Yes No Explain:

Major illness, injury, hospitalization, surgery (since last visit)

Allergies
Medications taken regularly, Type/Reason:
Dental Care:

PHYSICAL EXAMINATION hct/hgb___ lead___

Temp _____ Pulse _____ Resp _____
HC _____ Height _____ Weight: _____
(%) _____ (%) _____ (%) _____

N	A	NE	
☐	☐	☐	Appearance
☐	☐	☐	Head/fontanels
☐	☐	☐	Skin-nodes
☐	☐	☐	Eyes
☐	☐	☐	Ears
☐	☐	☐	Nose
☐	☐	☐	Mouth/throat
☐	☐	☐	Teeth
☐	☐	☐	Neck
☐	☐	☐	Chest-breasts
☐	☐	☐	Heart/pulses
☐	☐	☐	Lungs
☐	☐	☐	Abdomen
☐	☐	☐	Genitalia/Anus
☐	☐	☐	Spine/hips
☐	☐	☐	Extremities
Neurologic:			
☐	☐	☐	Muscle tone
☐	☐	☐	DTRs

Explain Abnormalities:

HEALTH EDUCATION

INJURY PREVENTION
_ Car safety restraints
Choking, crib safety
_ Poisoning
_ Burns
_ Water safety (drowning)
_ Outdoor safety
_ Supervised play
_ Electrical injury
_ Passive smoking

DEVELOPMENT
_ Parent-infant interaction
_ Social interaction
_ Limit TV
_ Set limits
_ Weaning to cup
Toilet training

HEALTH PROMOTION
_ Immunizations
_ Smoke-free home
Well-child care
_ Dental care/appt
_ Family planning
_ Daycare

NUTRITION
_ Physical activity
_ Weaning

_ Other (specify)

ASSESSMENT

PLAN

Dental referral made: _ Yes _ No WIC _ Referred _ Refused _ N/A
Immunizations _ Up-to-date _ To be given today Deferred (Explain)
Next appointment:

Date _ Signature/Title: _____ _____ Signature/Title: _____ ___ __ _____

If used for documentation:
Patient's Name: ____________
Date: ____________

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, wandering eye movement
Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuro: Seizures, coordination, gait
Musculoskeletal: Fractures

MENTAL HEALTH

The mental health assessment for this age also includes the developmental assessment, and information from the family profile

Feelings: Angry, sad, fearful, sullen, anxious, cries excessively/too little
Behavior: Overactive, listless, harms other, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

DEVELOPMENT

15 Months	18 Months	2 Years
Waves bye-bye	Drinks from a cup	Uses spoon
Is interested in all sounds around him	Brings you item when asked (no pointing)	Builds tower of 2 cubes
Puts block in cup	Says six words	Combines 2 words
Uses vocalization to request objects and direct attention	Asks for familiar toys that are not around	Follows 2-part directions
Stoops and recovers	Responds to "give me"	Kicks ball forward
	Walks backwards	

PROGRESS NOTES

7.7 Child Health Record (3 to 5 Years) (2 pages)

3-5 YEARS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
PREVENTIVE HEALTH VISIT

Age: ____
Informant/Relationship: _____

NAME: _____
DOB _____ SEX: _____
SSN/RECORD # _____
RACE/ETHNICITY _____
Medical Home: _____

FAMILY PROFILE AND HEALTH _ No change in household since last visit

Child lives with ___Mother ___Father ___Stepparent ___Grandparent __ Other Total adults living in home _____
Total children living in home: ____ Primary caretaker for this child: _____ ____ Relationship: _____
Family's concerns/problems:

NUTRITION *Problems: special diet, inappropriate weight gain/loss, anemia, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental. _ Y _ N

Usual Servings Per Day Dairy __ Vegetables Breads, cereal, rice and pasta WIC _ Y _ N
__ Meat, poultry, fish, eggs and dry beans __ Fruits Fluoride
* If answered yes, further assessment needed Supplement: Y N

DEVELOPMENT Parent's concerns:

Standardized Parent Questionnaire: _ P _ F _ Not Done**
Standardized Observational Screen: _ P _ F _ Not Done**
Further assessment needed: Yes No
** *Document reason if neither screen was completed.*

Mental Health (see key elements):

SENSORY

Vision screen: Normal _ Abnormal

Hearing screen _ Normal _ Abnormal
Screen used: ABR
_ OAE
_ TDH Hearing Checklist

CHILD'S HEALTH Does the systems review raise any problems or parent concerns __ Yes __ No Explain.

Major illness, injury, hospitalization, surgery (since last visit):

Allergies
Medications taken regularly: Type/Reason:
Dental Care:

PHYSICAL EXAMINATION Ht: ____ Hgb ____ lead ____

Temp _____ Pulse _____ Resp _____
BP _____ Height _____ (%ile) Weight _____ (%ile)

N	A	NE	
☐	☐	☐	Appearance
☐	☐	☐	Head
☐	☐	☐	Skin nodes
☐	☐	☐	Eyes
☐	☐	☐	Ears
☐	☐	☐	Nose
☐	☐	☐	Mouth/throat
☐	☐	☐	Teeth
☐	☐	☐	Neck
☐	☐	☐	Chest/breasts
☐	☐	☐	Heart/pulses
☐	☐	☐	Lungs
☐	☐	☐	Abdomen
☐	☐	☐	Genitalia/Anus
☐	☐	☐	Spine
☐	☐	☐	Extremities
Neurologic:			
☐	☐	☐	Muscle tone
☐	☐	☐	DTRs

Explain Abnormalities:

HEALTH EDUCATION

INJURY PREVENTION
_ Car safety restraints
_ Poisoning
Fire safety
_ Pregnancy
Street, water, bicycle safety
_ Scissors, sharp objects
_ Stranger safety
_ Teach telephone number and address
Self-safety
_ Passive smoking

BEHAVIOR
_ Talk/read with child
_ Exploration
_ Limit television
Discipline, consistency
_ Toilet training
_ Sex information
School readiness
_ Socialization

HEALTH PROMOTION
Immunizations
_ Well child care
Dental care appt
_ Family Planning
_ Daycare

NUTRITION
_ Healthy diet/snacks
_ Junk food
_ Iron rich foods
_ Physical activity

ASSESSMENT

PLAN

Dental referral made: _ Yes No WIC Referred Refused _ N/A
Immunizations: _ Up to date _ Declined _ Parental Explan
Next appointment:

Date: _ _ Signature/Title _____ ____ ... ___ Signature/Title: _____

If used for documentation:
Patient's Name: _____
Date: _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, blinking, tearing
Nose, Mouth/Throat: Nasal congestion

Cardiorespiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, soiling
Genitourinary: Dysuria, discharge
Neuro: Seizures, gait, coordination
Musculoskeletal: Fractures

MENTAL HEALTH

The mental health assessment for this age also includes the developmental assessment, and information from the family profile.

Feelings: Out of control, angry, sad, fearful, sullen, anxious
Behavior: Overactive, listless, harms others or property, sexually acts out, impulsive, frequently provokes other children, self abuses
Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally
Thinking: Mistrustful, distracted, is frustrated easily
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

DEVELOPMENT

3 Years	4 Years	5 Years
Brushes teeth with help	Puts on T shirt	Brush teeth - no help
Tower of 6 cubes	Wiggle thumb	Copies +
Uses pronouns, I, you, me	Expresses needs, ideas in 3-6 word sentences	Carries on a conversation
Throws ball overhand	Balances on 1 foot, 2 sec	Balances on 1 foot, 3 sec

PROGRESS NOTES

7.8 Child Health Record (6 to 12 Years) (2 pages)

6–12 YEARS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
PREVENTIVE HEALTH VISIT

Age: ____
Informant/Relationship: _____

NAME: _____
DOB: ___/___/___ SEX: _____
SSN/RECORD # _____
RACE/ETHNICITY _____
Medical Home: _____

FAMILY PROFILE AND HEALTH _ No change in household since last visit

Child lives with: __Mother __Father __Stepparent Grandparent Other Total adults living in home: _____
Total children living in home: Primary caretaker for this child _____ Relationship _____
Family's concerns/problems:

MENTAL HEALTH: + indicates need for further assessment)

Sleep problems
Behavior problems
Relationship problems with parents, siblings, peers
_ Problems in school/Grade Level___
_ Special education classes
_ No/excessive extracurricular activities
_ Substance abuse/use
_ Self-concept problems

Comments:

NUTRITION *Problems: special diet, inappropriate weight gain/loss, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group __ Yes __ No

Usual Servings Per Day
__ Dairy
__ Meat, poultry, fish, eggs and dry beans
__ Vegetables
__ Fruits
__ Breads, cereal, rice and pasta
* If answered yes, further assessment needed

CHILD'S HEALTH Does the systems review note any problems or parent concerns: __ Yes __ No Explain:

Major illness, injury, hospitalization, surgery (since last visit):
Allergies:
Dental care/Sealants:
Medications taken regularly, Type/Reason:

PHYSICAL EXAMINATION Int/Orth__ .

Temp _____ Pulse _____ Resp _____
BP ___ . Height _____ Weight _____
(%) _____ (%) _____
Vision screen: Normal_____ Abnormal____
Hearing screen Normal_____ Abnormal_ .

NAME
☐☐☐ Appearance
☐☐☐ Head
☐☐☐ Skin/nodes
☐☐☐ Eyes
☐☐☐ Ears
☐☐☐ Nose
☐☐☐ Mouth/throat
☐☐☐ Teeth
☐☐☐ Chest/breasts (Tanner stage)
☐☐☐ Neck
☐☐☐ Heart/pulses
☐☐☐ Lungs
☐☐☐ Abdomen
☐☐☐ Genitalia/Anus (Tanner stage)
☐☐☐ Spine
☐☐☐ Extremities
Neurologic:
☐☐☐ Muscle tone
☐☐☐ DTRs
Explain Abnormalities

HEALTH EDUCATION

INJURY PREVENTION	BEHAVIOR	HEALTH PROMOTION
_ Seat belt/Auto safety	_ Substance abuse	_ Limit TV viewing
_ Bicycles/ATV	_ Tobacco use	_ Passive smoking
_ Athletics	_ Security	_ Regular exercise
_ Water safety	_ Discipline patterns	_ Pubertal changes/ sexuality
_ Smoke detectors	_ Responsibility	_ Dental care/ sealants
_ Firearm safety	_ Communication/ Conflict resolution	
NUTRITION		
_ Healthy diet/fitness	_ Junk food	_ Time with family

ASSESSMENT

PLAN

Dental Referral Made: _ Yes _ No
Immunizations: _ Up to date _ To be given today Deferred (Explain):
_____
Next appointment:

Date _____ Signature/Title: _____ Signature/Title: _____ (continued)

If used for documentation:
Patient's Name: _____
Date _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, infections
Eyes: Eye discharge, blinking, tearing
Ears: Hearing or ear problems
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardiorespiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, encopresis
Genitourinary: Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis
Neuro: Seizures
Musculoskeletal: Fractures, sprains, sport injuries

PROGRESS NOTES

7.9 Child Health Record (10 to 20 Years) (2 pages)

10-20 YEARS
TEXAS DEPARTMENT OF HEALTH
CHILD HEALTH RECORD
PREVENTIVE HEALTH VISIT

Age _____
Informant/Relationship: _____

NAME: _____
DOB ___/___/___ SEX _____
SSN/RECORD #: _____
RACE/ETHNICITY: _____
Medical Home: _____

FAMILY PROFILE AND HEALTH _ No change in household since last visit

Adolescent lives with: _Mother _Father _Stepparent _Grandparent _Other (identify) _____
Total adults living in home: ____ Total children living in home: ____ Primary caretaker for this adolescent: _____
Relationship: _____ Family's concerns/problems: _____

MENTAL HEALTH (+ indicates need for further assessment)

Sleep problems
_ Relationship problems with parents, siblings, peers
Adjustment to pubertal changes
_ Contact with juvenile legal/justice system
_ Problems in school Grade level _____
_ Non-excessive extracurricular activities
_ Substance abuse
_ Depression/suicidal thoughts
School age parent/pregnant
_ Eating disorders
_ Sexually active
_ Physical/sexual abuse
_ Risk taking behavior

NUTRITION *Problems: therapeutic diet, self-prescribed diet, inappropriate weight, anemic, chronic gastrointestinal problems, major food allergies, refusal of any food group Yes No

Usual Servings Per Day:
__ Dairy
__ Meat, poultry, fish, eggs and dry beans
__ Vegetables
__ Fruits
__ Breads, cereal, rice and pasta
* If answered yes, further assessment needed

ADOLESCENT'S HEALTH Does the systems review note any problems or parent concerns: _ Yes __ No Explain:

Major illness, injury, hospitalization, surgery (since last visit)

Allergies:
Medications taken regularly, Type/Reason:
Dental care/Sealants:
Menstrual: Menarche Frequency of menses__days Duration____ Problems.

PHYSICAL EXAMINATION ht/wgt___

Temp _____ Pulse Resp ____
BP _____ Height Weight _____
(%) _ (%) _____
Vision screen: Normal_____ Abnormal____
Hearing screen: Normal_____ Abnormal ____

N A NE
☐ ☐ ☐ Appearance
☐ ☐ ☐ Head
☐ ☐ ☐ Skin/nodes
☐ ☐ ☐ Eyes
☐ ☐ ☐ Ears
☐ ☐ ☐ Nose
☐ ☐ ☐ Mouth/throat
☐ ☐ ☐ Teeth
☐ ☐ ☐ Chest/breasts (Tanner stage)
☐ ☐ ☐ Neck
☐ ☐ ☐ Heart/pulses
☐ ☐ ☐ Lungs
☐ ☐ ☐ Abdomen
☐ ☐ ☐ Genitalia/Anus (Tanner stage)
☐ ☐ ☐ Pelvic Exam
☐ ☐ ☐ Spine
☐ ☐ ☐ Extremities
Neurologic:
☐ ☐ ☐ Muscle tone
☐ ☐ ☐ DTRs
Explain Abnormalities:

HEALTH EDUCATION

INJURY PREVENTION	BEHAVIOR	HEALTH PROMOTION
_ Car/motorcycle safety	_ Alcohol use	_ Family planning
_ Firearms	_ Substance abuse	_ Immunizations
_ Abuse prevention	_ Tobacco use	Sun exposure
_ 911	_ Sexuality	Passive smoking
_ Water safety	Interpersonal relationships	Dental care/ sealant
	_ Conflict resolution	_ Limit television
NUTRITION		
Healthy diet/snacks	_ Physical activity	
Iron rich foods	_ Weight management	

ASSESSMENT

PLAN

Dental Referral Made Yes No
Immunizations Up to date _ To be given today _ Deferred (Explain)

Next appointment:

Date:____ Signature/Title:_____ Signature/Title:_____

If used for documentation:
Patient's Name: _____
Date: _____

KEY ELEMENTS

SYSTEMS REVIEW

Skin: Rashes, acne, moles, warts, tattoos
Ears: Hearing or infections
Head: Headaches
Eyes: Vision problems, glasses
Nose/Mouth/Throat: Frequent colds, sore throats
Dental: Caries, braces

Cardiovascular: History of murmur, palpitations, chest pain, sports endurance
Respiratory: Cough, smoking, TB, asthma, shortness of breath
Gastrointestinal: Abdominal pain
Genitourinary: Dysuria, vaginal itch/burning, discharge
Neuro: Seizures, dizziness
Musculoskeletal: Fractures, joint pain, sports injuries

PROGRESS NOTES

7.10 24-Hour Dietary Recall, Assessment for Infants (Birth to 11 Months) (2 pages)

Diet History *(Provide all answers except in shaded areas)*
Dietary Recall and Assessment for Infants
Birth through 11 Months

Name: _____

DOB: _____ Age: _____

Assessment Questions for Infants	Risk Conditions Defined	Code
All Infants: Is your infant following therapeutic diet/special feeding instructions? Yes __ No __ Describe: _____ Does your infant have any developmental feeding problems? ..... Yes ____ No ____ Describe: _____	**Developmental, Sensory or Motor Delays Interfering with the Ability To Eat** Disabilities that restrict the ability to chew or swallow food or require tube-feeding to meet nutritional needs	362
Breastfed Infant (Total or Partial): How many feedings in past 24 hours _____ Length _____ Problems with breastfeeding? _____ How many wet diapers per day? _____	**Infrequent Breastfeeding as Sole Source of Nutrients:** Totally breastfed (no formula/solids) ▪ younger than 2 months – less than 8 feedings in 24 hours ▪ 2 months or older – less than 6 feedings in 24 hours **Breastfeeding Complications/Potential Complications:** ▪ jaundice, weak/ineffective suck, latching difficulties ▪ less than 6 wet diapers per day	418 603
Formula-Fed Infant: Brand/type of formula or milk: _____ ____ Powder ____ Concentrated ____ Ready-to-Use Is formula iron fortified? ..... Yes ____ No ____ If NO, is your infant taking iron drops? ..... Yes ____ No ____ How is formula diluted and mixed? _____ Is anything added to the formula besides water? ..... Yes ____ No ____	**Feeding Cow's Milk** **Inappropriate Infant Feeding:** ▪ feeding goat's milk, sheep's milk, imitation milks, or substitute milks ▪ formula feeding only ▪ 0-6 months – feeding low iron formula without iron supplementation **Improper Dilution of Formula** **Adding honey** **Adding corn syrup, sugar...**	413 411 415 411 416
Bottle-Fed Infant, Breastmilk and/or Formula: Number of bottles made at one time _____ Amount of breastmilk/formula in each bottle _____ Amount of breastmilk/formula consumed at each feeding _____ Number of bottles consumed in 24 hours _____ Total amount of breastmilk/formula consumed in 24 hours _____ How long does one can of formula last? _____ Is water boiled before it is mixed with formula? ..... Yes ____ No ____ What is done with leftover breastmilk/formula in the bottle? _____ How are bottles/equipment cleaned? _____ How are bottles of breastmilk/formula stored? _____ Do you... ▪ put the baby to bed with a bottle? ..... Yes ____ No ____ ▪ prop the bottle? ..... Yes ____ No ____ ▪ let the baby crawl or walk around with the bottle or use the bottle to pacify the baby? ..... Yes ____ No ____ ▪ use the bottle to feed liquids other than breastmilk, formula, or water? ..... Yes ____ No ____	**Inappropriate Infant Feeding** Inadequate Amount, Nonbreastfed Only: ▪ 0-3 months – less than 20 oz. in 24 hours ▪ 4-5 months – less than 26 oz. in 24 hours ▪ 6-11 months – less than 24 oz. in 24 hours Excessive amount, Nonbreastfed Only: ▪ 0-4 months – more than 40 oz. in 24 hours ▪ 5-9 months – more than 36 oz. in 24 hours ▪ 10-11 months – more than 32 oz. in 24 hours **Lack of Sanitation in Preparation or Handling** ▪ Younger than 3 months and water not boiled ▪ unsafe water ▪ no stove ▪ feeding formula that has been at room temperature longer than 2 hours, stored in refrigerator longer than 48 hours, or left from another feeding **Inappropriate Use of Nursing Bottles** ▪ yes to any	411 417 419
All Infants: Have any foods/beverages other than formula/breastmilk been introduced? _____ If yes, during what month? _____ **Continue to the next section on the other side.**	**Early Introduction of Solid Foods** ▪ solids introduced before 4 months **Inappropriate Infant Feeding** ▪ no solids introduced by 7 months **No Dependable Source of Iron After 6 Months** no iron-fortified formula, iron-fortified cereals, meats, or oral iron supplements	412 411 414

Recall taken by: _____ Date: _____

Recall assessed by: _____

Texas Department of Health WIC-42 Rev. 5/24/99

Name _____ Date: _____

24-Hour Infant Diet Recall

What foods/beverages, other than breastmilk or formula, have you given the baby in the last 24 hours? (List amounts.)	**No Dependable Source of Iron After 6 Months** ▪ no iron-fortified formula, iron-fortified cereals, meats, or oral iron supplements	414
	Vegan Diets ▪ no animal or dairy products	402
	Highly Restrictive Diets ▪ very low in calories, severely limits intake or important food sources of nutrients, restricts timing or combination of foods, or other high-risk eating patterns	403
Is your baby finger feeding or eating finger foods? ..... Yes ____ No ____	**Inappropriate Infant Feeding** ▪ 7–9 months — infant not beginning to finger feed ▪ fed or feeding foods that could cause choking	411
How are solid foods fed to baby? _____	**Inappropriate Infant Feeding** ▪ feeding solids in the bottle or infant feeder ▪ use a syringe-type feeder ▪ not using a spoon for solids	411
Do you... give water? Yes____ No____ how much?_____ give tea or coffee? ..... Yes ____ No ____ give colas or other sweetened beverages? ..... Yes ____ No ____ give other high calorie nonnutritious foods? (corn syrup, sugar, or salt) ..... Yes ____ No ____	**Feeding Foods Low in Essential Nutrients** ▪ more than four oz. of water per day ▪ any amount of tea, coffee, cola, or caffeine-containing foods ▪ any sweetened beverages or high-calorie foods	416
give honey? ..... Yes ____ No ____	**Inappropriate Infant Feeding** ▪ give honey	411

WIC Health History for Infants

Please answer the following questions:	Comments (For Staff Use Only)	NV	Code
Was your infant born with any medical problems? ..... Yes ____ No ____			
Has your infant ever had any health problems? ..... Yes ____ No ____			
Has your infant been in the hospital (other than when born) or emergency room? ..... Yes ____ No ____			
Is your infant on a special diet for medical reasons? ..... Yes ____ No ____			
Are there any foods that you limit, avoid, or do not give your infant for any reason? ..... Yes ____ No ____			
Is your infant taking any medications? ..... Yes ____ No ____			357
Has your infant had: surgery? ..... Yes ____ No ____ burns? ..... Yes ____ No ____ serious injury? ..... Yes ____ No ____			359
Do you give your infant: herbal medicine? ..... Yes ____ No ____ vitamins/minerals? ..... Yes ____ No ____ herbal tea? ..... Yes ____ No ____	(Inappropriate or Excessive) (Fluoride, Iron)		423 424
Do you have: a working stove? ..... Yes ____ No ____ a working refrigerator? ..... Yes ____ No ____ running water? ..... Yes ____ No ____			
Are you afraid that someone you know may injure or harm your infant? ..... Yes ____ No ____	**National Domestic Violence Hotline at 1-800-799-7233**		901
Where does your infant get health care and how long since the last visit? Doctor: _____ Shots: _____ Clinic: _____ ____ 1 - 3 months? ____ 4 - 6 months? ____ 7 - 9 months? ____ 10-12 months?			

WIC Growing Healthy Families

TDH

7.11 24-Hour Dietary Recall, Assessment for Children (1 to 4 Years) (2 pages)

24–Hour Dietary Recall and Assessment for Children
One through Four Years

Name:_____
DOB:_____
Age:_____
SSN/Record#:_____

Required for WIC

Required for Child Health (optional for WIC)

List all foods and beverages consumed in the past 24 hours or previous day	**Amount Consumed**

Medical Risks

*Is child underweight, overweight, or does the child have poor growth?
Yes ___ No ___ If yes, list_____
*Does child have anemia? Yes ___ No ___
*Does child have lead poisoning? Yes ___ No ___
*Does the child have chronic vomiting, diarrhea, or constipation
Yes ___ No ___ If yes, list _____

Resources

Working stove/refrigerator? Yes ___ No ___
___ WIC ___ Food stamps
___ Meals in daycare ___ Food pantry/soup kitchen
___ Summer food program
Do you need help in obtaining food? Yes ___ No ___

Feeding Skills

Is child weaned from bottle by 18 months? Yes ___ No ___
Is child able to feed self after two years? Yes ___ No ___ N/A___
*Does child have any feeding problems? Yes ___ No ___
Check any that apply:
___ sucking ___ gagging ___ swallowing
___ choking ___ chewing
___ other, list:_____

Dietary Practices

*Is child on a theraputic/special diet? Yes ___ No ___
Describe: _____ Prescribed by _____
*Any major food allergies Yes ___ No ___
If yes, list: _____ Symptoms _____
*Any food groups refused/omitted? Yes ___ No ___
If yes, list: _____
Does child eat dirt, clay, paint chips, or other non-foods?
Yes ___ No ___
Does child under three eat hot dogs, grapes, nuts, popcorn, or hard candies?
Yes ___ No ___ N/A ___
Does child/family eat or avoid any special foods for religious or health reasons?
Yes ___ No ___
If yes, describe: _____

Health Habits

Hours of TV/day: _____
Physical activity: _____ active _____ moderate _____ inactive
Given how many meals daily? _____
Are meals eaten with family? Yes ___ No ___
Are snacks given? Yes ___ No ___
If yes, list: _____
How many snacks per day? _____ How often are child's teeth brushed? _____
Encouraged to clean plate Yes ___ No ___
Vitamin/minerals pills? Yes ___ No ___
If yes, list brand/type _____

Minimum Daily Servings

WIC Deficiencies

Milk _____
Meat _____
Frt/Veg _____
Vit A _____
Vit C _____
Brd/Cer _____
Total ☐

Nutrition Education

___ weaning from bottle ___ feeding skills
___ pica/lead poisoning ___ foods that cause choking
___ obesity prevention treatment ___ healthy snacks
___ dental health ___ healthy diet
___ low-fat diet (>2 yrs) for heart health ___ whole milk only (<2 yrs)
___ inadequate/excessive intake of _____
___ other: _____

Date _____ Counseled by _____

RECALL TAKEN BY:_____

RECALL ASSESSED BY: _____

* If yes to any question, complete a 24–hour dietary recall.

Date: _____

Progress Notes

Date

7.12 24-Hour Dietary Recall, Assessment for Children (5 to 9 Years) (2 pages)

24–Hour Dietary Recall and Assessment for Children
Five through Nine Years

Name:_____
DOB:_____
Age:_____
SSN/Record#:_____

List all foods and beverages consumed in the past 24 hours or previous day	Amount Consumed

Medical Risks

*Is child underweight, overweight, or does the child have poor growth?
Yes ___ No ___ If yes, list_____
*Does child have anemia? Yes ___ No ___
*Does child have lead poisoning? Yes ___ No ___
*Does the child have chronic vomiting, diarrhea, or constipation
Yes ___ No ___ If yes, list _____

Resources

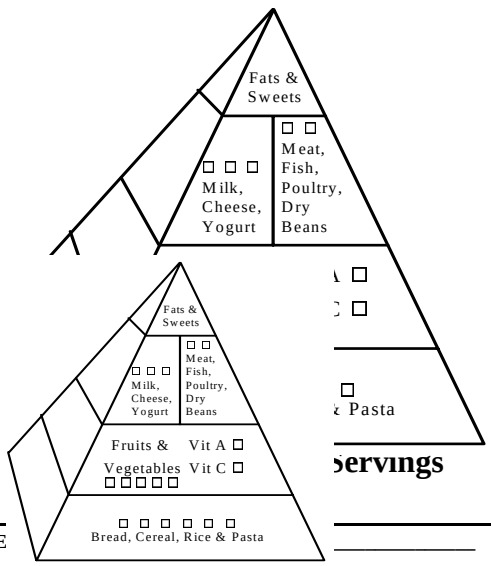
Working stove/refrigerator? Yes ___ No ___
___ School breakfast ___ Food stamps
___ School lunch ___ Food pantry/soup kitchen
___ Summer food program
Do you need help in obtaining food? Yes ___ No ___

Dietary Practices

*Is child on a theraputic/special diet? Yes ___ No ___
Describe: _____ Prescribed by _____
GI problems with milk products? Yes ___ No ___
*Any major food allergies? Yes ___ No ___
If yes, list: _____ Symptoms _____
*Any food groups refused? Yes ___ No ___
If yes, list: _____
Does child/family eat or avoid any special foods for religious or health reasons?
Yes ___ No ___
If yes, describe: _____

Health Habits

Hours of TV/day: _____
How many days per week does child exercise? ____
What type of exercise? _____ How long? _____
Given how many meals daily? _____
Are meals eaten with family? Yes ___ No ___
Are snacks given? Yes ___ No ___
If yes, list: _____
How many snacks per day? _____ How often does child brush teeth? _____
Encouraged to clean plate Yes ___ No ___
Vitamin/minerals pills? Yes ___ No ___
If yes, list brand/type _____



Nutrition Education

___ Physical activity ___ iron rich foods
___ GI disturbances or problems with milk ___ weight management
___ healthy diet ___ healthy snacks
___ dental health
___ low-fat diet for heart health
___ inadequate/excessive intake of _____
___ other: _____

Date _____ Counseled by _____

RE _____

* If yes to any question, complete a 24–hour dietary recall.

RECALL ASSESSED BY: _____ **Date**: _____

Progress Notes

Date

7.13 24-Hour Dietary Recall, Assessment for Children (10 to 20 Years) (2 pages)

24–Hour Dietary Recall and Assessment for Teens
10 through 20 Years (non-pregnant teens)

Name:_____
DOB:_____
Age:_____
SSN/Record#:_____

List all foods and beverages consumed in the past 24 hours or previous day	Amount Consumed

Medical Risks

*Is child/teen underweight, overweight, or have poor growth?
Yes ___ No ___ If yes, list_____
*Does child/teen have anemia? Yes ___ No ___
*Does child/teen have lead poisoning? Yes ___ No ___
*Does the child/teen have chronic vomiting, diarrhea, or constipation
Yes ___ No ___ If yes, list _____

Resources

Working stove/refrigerator? Yes ___ No ___
___ School breakfast ___ Food stamps
___ School lunch ___ Food pantry/soup kitchen
___ Summer food program
Do you need help in obtaining food? Yes ___ No ___

Weight Loss Practices

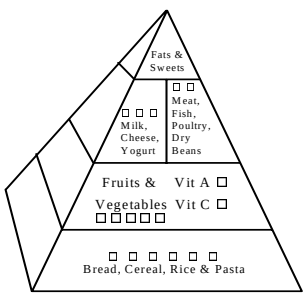
How do you feel about your weight? Good ___ Bad ___
*Any restrictive dieting practices? Yes ___ No ___
Circle any that apply:
Skip meals Diet pills Vomiting
Laxatives
Diet supplements or fad diets? Yes ___ No ___
If yes, describe: _____
Do you feel your eating is out of control? Yes ___ No ___

Dietary Practices

*Any theraputic/special diet? Yes ___ No ___
Describe: _____ Prescribed by _____
GI problems with milk products? Yes ___ No ___
*Any major food allergies? Yes ___ No ___
If yes, list: _____ Symptoms _____
*Any food groups refused? Yes ___ No ___
If yes, list: _____
Does you eat or avoid any special foods for religious or health reasons?
Yes ___ No ___
If yes, describe: _____

Health Habits

Hours of TV/day: _____
How many days per week do you get exercise/physical activity?_____
What type of exercise? _____ How long? _____
How many meals are eaten daily? _____
Are snacks eaten daily? Yes ___ No ____
If yes, list: _____
How many snacks per day? _____ Fast food eaten: _____
Alcohol/tobacco/street drugs used? Yes ___ No ____
If yes, what kind? _____ How often? _____ How much? _____
Vitamin/minerals pills? Yes ___ No ____
If yes, list brand/type _____



Minimum Daily Servings

Counseled on:

___ healthy diet
___ nutrition for sports
___ healthy snacks
___ iron-rich foods
___ physical activity
___GI disturbances or problems with milk
___ inadequate/excessive intake of _____
___ other: _____
___ weight management/fad diets
___ eating regular meals 3x/day
___ healthy "fast food" choices
___ calcium-rich foods
___ smoking/alcohol/drugs
___ low-fat eating for heart health

Date _____ Counseled by _____

RECALL TAKEN BY:_____

RECALL ASSESSED BY: _____

* If yes to any question, complete a 24–hour dietary recall.

Date: _____

Progress Notes

Date

7.14 Guidelines for Mental Health Screening (2 pages)

Guidelines for Mental Health Screening

- **The mental health screen,** ideally, is part of every comprehensive well-child check-up. The attached age-specific interview tools and parent questionnaires are provided as an option for performing this screen. They are intended for use as part of a comprehensive pediatric assessment. If these interview tools are used outside the context of a comprehensive examination the interviewer must remember to collect information usually gathered in a pediatric history: household members, prenatal/newborn history, child's health history, family illnesses.

- **The purpose of the mental health screen** is to identify problems in any of six domains: feelings, behavior, social interactions, thinking, physical problems, and other problems which may include substance abuse. The provider choosing alternative screening tools or techniques should be certain to screen in these domains. Screening may reveal several minor problems or one or more significant problems that warrant referral for/or provision of evaluation and, if indicated, treatment. In determining whether behaviors are serious enough to warrant referral the screener must weigh the extent and intensity of the problems and explore the child's resiliency and positive behaviors. If the child has been or is under treatment for any mental health conditions, record in the child's medical record.

- **Referral options** may include parenting education programs, early childhood intervention programs (ages 0-3), mental health evaluation and counseling, substance abuse programs, acute psychiatric hospitalization, or child protective services. The screener's responsibility is to identify and establish a referral relationship with these resources in the community.

  Concerning recommendations in this document to refer a child for evaluation and treatment: Screeners with special training and credentials allowing evaluation and treatment of childhood behavior problems, mental illness, or substance abuse may choose to provide these services rather than referring. Other screeners should refer to these specialists.

- **Confidentiality**: The screener introduces the screen by explaining that the information provided will be held in strictest confidence unless the screener recognizes situation that places the child or others in danger.

  Children over the age of four years should not be present when the screener questions the parent regarding possible abuse or neglect. Beginning at about age 10 years, questions about peer and family social interaction and substance abuse are explored with the child and parent separately. All parts of the screen are administered to the adolescent and their parent/caregiver separately.

  If observations of the child, the parent or the parent-child interaction lead the screener to suspect possible abuse or neglect, the screener must make a report to Child Protective Services. The report is required even though the screener may refer a family for evaluation or treatment of abuse/neglect.

- **Behavior of particular concern**: Behavior generally expressive of mental health problems include those listed below. If the screener finds any of the following significant behaviors, further

screening is unnecessary, since referral is indicated:

setting fires

suicidal behavior or ideation

self-destructive activities

torturing animals

hurting other people

destroying property

loss of touch with reality

inappropriate sexual behavior

substance abuse

parental concern about their ability to maintain the child in the home.

- **Important**: At the conclusion of a screening which is judged by the provider to be within normal limits, if the parent of older child remains concerned that the child has mental health problems or problem behavior, the screener should refer the child for a comprehensive mental health evaluation.

- **Interview Tools/Referral Forms**

  The following pages contain age-specific questions to guide the provider. Items of concern should be circled. Extensive notes may have to be made on a separate sheet. A copy of this form may be used as a referral form.

- **The parent questionnaire** is similar to the interview tool. It is advisable in the first visit to explain and administer the interview face to face. At subsequent visits the age-appropriate form may be given to the literate parent or adolescent with the instruction, "Circle any of these items that you feel are a problem for your child/you and that you would like to discuss with your provider."

7.15 Guidelines for Mental Health Screening (2 Pages) (Spanish)

- **Una breve evaluación de la salud mental**, forma parte idealmente de cada examen detallado de salud de los niños saludables. Los cuestionarios para los padres y los instrumentos para las entrevistas, específicos para ciertos grupos de acuerdo a la edad, se encuentran adjunto como opciones para hacer la breve evaluación mental. Estos cuestionarios son para que se usen como parte de una evaluación pediátrica completa. Si estos cuestionarios se usan fuera del contexto de un examen detallado, el entrevistador debe acordarse de obtener la información que generalmente se obtiene en un historial pediátrico: miembros de la familia, historial prenatal, de nacimiento y de recién nacido, el historial de la salud del niño, las enfermedades de la familia.

- **El propósito de la breve evaluación de la salud mental** es para identificar problemas en cualquiera de las siguientes seis áreas: sentimientos, comportamientos, interacciones sociales, pensamientos, problemas físicos, y otros problemas que pueden incluir el abuso de sustancias como drogas y bebidas alcohólicas. El proveedor que prefiera otros instrumentos de detección o técnicas debe asegurarse de hacer breves evaluaciones en estas áreas. El hacer breves evaluaciones puede sacar a flote problemas secundarios o uno o más problemas significantes que justifican el referir a la persona con un especialista o hacer una evaluación, y si se le ha indicado, darle un tratamiento. Al determinar si los comportamientos son lo suficientemente graves para justificar que la persona sea referida a un especialista, la persona que conduce la breve evaluación debe tomar en cuenta lo grave y lo intenso del problema y explorar la inconsistencia del carácter y el comportamiento positivo del niño. Si el niño ha estado o está bajo tratamiento debido a algún estado de salud mental, apúntelo en el expediente médico del niño.

- **Los lugares a donde puede referir al niño para recibir ayuda** pueden incluir programas educacionales sobre el ser padres, programas de intervención temprana en la niñez (de edades 0-3), consultas de consejos y evaluaciones de la salud mental, programas para el abuso de sustancias como las drogas y las bebidas alcohólicas, hospitalización psiquiátrica grave, o servicios de protección del niño. La persona que conduce la breve evaluación es responsable de identificar y establecer una relación con estos recursos en la comunidad por la cual se puedan enviar a personas para recibir servicios especiales.

  Con respecto a las recomendaciones en este documento de enviar a los niños a evaluaciones y tratamiento: Las personas que llevan a cabo las breves evaluaciones que tengan la capacitación especial y las credenciales que permiten poder evaluar y tratar los problemas de comportamiento de niños, enfermedades mentales, o del abuso de sustancias como drogas y bebidas alcohólicas pueden optar por proveer ellos mismos estos servicios o enviar al niño con un especialista. Las otras personas deberán enviar a los niños con estos especialistas.

- **Confidencialidad:** La persona conduciendo la breve evaluación, debe introducirla explicando que la información proveída se mantendrá estrictamente confidencial a menos que la persona conduciendo la breve evaluación detecte una situación que ponga al niño o a otros en peligro.

  Los niños mayores de cuatro años de edad no deben estar presentes cuando el entrevistador le haga preguntas a sus padres sobre la posibilidad de que haya habido abuso o negligencia. Comenzando desde los 10 años de edad, las preguntas sobre la interacción con los amigos y la familia y del abuso de sustancias como las drogas y las bebidas alcohólicas, deben hacerse al niño y a los padres individualmente. Todas las partes del cuestionario se le hacen al adolescente y a sus padres/personas encargadas individualmente.

Si las observaciones que se le hacen al niño, padres, o a la interacción entre ambos lleva al entrevistador a sospechar la posibilidad de abuso o negligencia, el entrevistador debe reportar esto a los Servicios de Protección del Niño (*Child Protective Services*). Se requiere que la situación se reporte aunque el entrevistador envíe a la familia para una evaluación o tratamiento de abuso/negligencia.

- **Comportamientos que conciernen en particular:** Los comportamientos que generalmente expresan problemas de salud mental incluyen los que se encuentran en la lista de abajo. Si el entrevistador encuentra alguno de los comportamientos significantes que aparecen a continuación, no se necesitan hacer más evaluaciones, ya que se recomienda que se envíe al niño con un especialista.

    - encender fuego
    - comportamiento de suicidio o de idealización
    - actividades de autodestrucción
    - torturar a los animales
    - lastimar a otras personas
    - destruir propiedad
    - perder el sentido de la realidad
    - comportamiento sexual inapropiado
    - abuso de sustancias como drogas o bebidas alcohólicas
    - preocupación de los padres sobre su capacidad de mantener al niño en la casa

- **Importante:** Si después de la breve evaluación los padres o el niño piensan que existen problemas de la salud mental o problemas de comportamiento, el entrevistador debe enviar al niño a una evaluación completa de la salud mental aunque no se hayan detectado estos problemas.

- **Los Instrumentos para la Entrevista/El Formulario para Tratamiento con un Especialista**

  Las siguientes páginas contienen preguntas específicas, según la edad del niño, para guiar al proveedor. Las características que le preocupen deben marcarse. Tal vez se tengan que escribir extensas notas en una hoja aparte. Se puede usar una copia de este formulario para enviar al niño con un especialista.

- **El cuestionario para los padres** es parecido al instrumento para la entrevista. Se recomienda que se explique y administre la entrevista de persona a persona durante la primera cita. En las citas siguientes se le puede entregar el formulario apropiado, según la edad, al padre o adolescente que sepa leer y escribir, con las instrucciones que indican: "Marque cualquiera de estas características que usted sienta son un problema para su niño/usted y de las cuales le gustaría hablar con su proveedor".

7.16 Mental Health Interview Tool/Referral Form (Ages 0 to 2 Years)

Mental Health Interview Tool/Referral Form

Ages 0 to 2

Child's Name: _____

Birth Date: _____

Date: _____

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings: Does your child display feelings that concern you or seem out of the ordinary?	Infants Anxious Cries excessively Cries too little	1 to 2 Years Irritable Sullen Angry Anxious Sad Cries excessively Fearful Cries too little
Behavior: Does your child display behavior that concerns you or seems out of the ordinary for his/her age?	Infants Overactivity Listlessness	1 to 2 Years Overactive Listlessness Harms others Frequent temper tantrums
Social Interaction: Do you have concerns about how your child gets along with you? Other family members or adults? Siblings?	Infants No eye contact or smile Stiffens and arches Not responsive	1 to 2 Years * No eye contact or smile Clings excessively Not responsive Language delay
Thinking: Do you think your child's development is normal for age?	Infants (> 8 months) No communication skills (pointing to request an object) or efforts to make words	1 to 2 Years Mistrustful Problems concentrating or paying attention
Physical Problems: Do you have any concerns about your child's physical health? If physical problems exist, have they been medically evaluated?	Infants to 2 Years Low weight or weight loss Frequent vomiting Eating problem (poor appetite, eats non-foods) Sleeping problem (frequent night waking) Lethargic	

Other: Are there any situations which are causing your family particular stress at this time?

Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse?

If yes, what form, when, treatment initiated, etc.?

Did the mother of this child use drugs or alcohol during the pregnancy?

Comments:

Signature/Title: _____

7.17 Mental Health Interview Tool/Referral Form (Ages 0 to 2 Years) (Spanish)

Instrumento para la Evaluación de la Salud Mental y Formulario para Tratamiento con un Especialista

De Recién Nacido a 2 Años de Edad

Nombre del Niño: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los niños que pertenecen a este grupo usted obtendrá información de los padres/personas encargadas y de sus propias observaciones del bebé. Marque las características que le preocupen. • La presencia de alguno de estos síntomas o comportamientos puede indicar que el niño está en una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.

Sentimientos: ¿Muestra su niño sentimientos que le preocupan o que parezcan extraños?

Recién Nacidos
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

De 1 a 2 Años
- ❑ Se irrita
- ❑ Se enoja
- ❑ Está triste
- ❑ Tiene miedo
- ❑ Malhumorado
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

Comportamientos: ¿Muestra su niño un comportamiento que le preocupa o que parezca extraño para su edad?

Recién Nacidos
- ❑ Es demasiado activo
- ❑ Es indiferente

De 1 a 2 Años
- ❑ Es demasiado activo
- ❑ Es indiferente
- ❑ Lastima a los demás
- ❑ Hace berrinches temperamentales frecuentemente

Interacciónes Sociales: ¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia o adultos? ¿Con sus hermanos?

Recién Nacidos
- ❑ No ve a los ojos ni sonríe
- ❑ Se pone tieso y se dobla arqueando la espalda
- ❑ No muestra mucho interés

De 1 a 2 Años
- ❑ • No ve a los ojos ni sonríe
- ❑ Se pega a usted excesivamente
- ❑ No muestra mucho interés
- ❑ Está atrasado en el lenguaje

Pensamientos: ¿Cree usted que el desarrollo de su niño es normal para su edad?

Recién Nacidos (> 8 meses)
- ❑ No tiene habilidad para comunicarse (apunta para pedir un objeto) ni se esfuerza para decir palabras

De 1 a 2 Años
- ❑ No tiene confianza
- ❑ Tiene problemas para concentrarse o para poner atención

Problemas Físicos: ¿Se preocupa sobre la salud física de su niño? Si existen problemas físicos, ¿han sido evaluados médicamente?

Recién Nacidos a 2 Años
- ❑ Peso bajo o pérdida de peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta frecuentemente por las noches)
- ❑ Es letárgico

Otra: ¿Hay alguna situación que le esté causando a su familia cierta tensión ahora?
¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional?
Si contesta sí, ¿de qué manera?, ¿cuándo?, ¿se ha comenzado algún tratamiento?, etc.
¿Usó la mamá de este niño drogas o tomó bebidas alcohólicas durante su embarazo?

Comentarios:

Firma/Título de su puesto: _____

TDH/OLS/6-395/10-96

7.18 Mental Health Interview Tool/Referral Form (Ages 3 to 9 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Ages 3 to 9

Date: _____

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child's behavior. If possible, interview the parent alone when asking questions about sexual or physical abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Does your child display feelings that concern you or seem out of the ordinary for age?

restless
sad or cries easily
excessively guilty
lack of remorse
irritable, angers or temper tantrums easily
sullen
fearful or anxious

Behavior:

Does your child frequently display behavior that seems out of the ordinary for age?

problems in school
* harms other children or animals
lacks interest in things s/he used to enjoy
engages in sexual play with others, toys, animals
* destroys possessions or other property
steals
refuses to talk
* sets fires
overactive
* self-destructive
* has been in trouble with the police (older child)

Social Interaction:

Do you have concerns about how child gets along with you, other family members, playmates, other adults?

withdraws including no eye contact
clings excessively
difficulty making and keeping friends
defiant, a discipline problem
severe or frequent tantrums
aggressive
argues excessively
refuses to go to school
prefers to be alone

Thinking:

Have you noticed any of the following to be a problem for your child?

* frequently confused
daydreams excessively
distracted, doesn't pay attention
* bizarre thoughts
mistrustful
* sees or hears things that are not there (excluding imaginary friends in younger children)
blames others for his/her misdeeds or thoughts
* talks about death
* frequent memory loss
schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

daytime wetting
soils pants
refusal to eat
headaches
excessive weight loss or gain
sleep problems, nightmares, sleep-walking, early waking
vomits frequently
frequent stomachaches
lacks energy

Other:

Is this child accident-prone?

Are there any situations that are causing your family particular stress?

Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse?

If yes, what type, when, treatment, etc.

* Is this child at risk for out-of-home placement because of behavior problems?

Comments:

Signature/Title: _____

7.19 Mental Health Interview Tool/Referral Form (Ages 3 to 9 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y Formulario para Tratamiento con un Especialista

De 3 a 9 Años de Edad

Nombre del Niño:_____
Fecha de Nacimiento:_____
Fecha:_____

Para los niños que pertenecen a este grupo usted obtendrá información de los padres/tutor y de sus propias observaciones del comportamiento del niño. Si es posible, entreviste a los padres solos cuando haga preguntas sobre el abuso sexual o físico. Marque las características que le preocupen. • La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y debe hacer un esfuerzo para asegurar que se le evalúe pronto.

Sentimientos:
¿Muestra su niño sentimientos que le preocupan o que parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Muestra mucha culpabilidad
- ❑ No tiene remordimiento
- ❑ Se irrita, enoja, o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Tiene miedo o está ansioso

Interacción Sociales:
¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia?¿Con otros adultos? o ¿Con sus amigos de juego?

- ❑ Se retira sin dirigir la mirada a los ojos
- ❑ Se pega a usted excesivamente
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Hace berrinches temperamentales fuertes o frecuentemente
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela
- ❑ Prefiere estar solo

Problemas Físicos:
¿Le preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ Se orina durante el día
- ❑ Se ensucia
- ❑ Se niega a comer
- ❑ Tiene dolores de cabeza
- ❑ Pérdida o aumento de peso excesivo
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano,
- ❑ Se vomita frecuentemente
- ❑ Tiene dolores de estómago frecuentemente
- ❑ No tiene energía

Comentarios:

Firma/Título de su puesto:_____

Comportamiento:
¿Muestra su niño frecuentemente un comportamiento que le parezca extraño para su edad?

- ❑ Problemas en la escuela
- ❑ • Lastima a otros niños o a animales
- ❑ No tiene interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ • Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Enciende fuegos
- ❑ Es demasiado activo
- ❑ • Tiene un comportamiento de autodestrucción
- ❑ • Ha tenido problemas con la policía (con otro niño)

Pensamientos:
¿Ha notado si alguno de los siguientes es un problema para su niño?

- ❑ • Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ • Tiene pensamientos raros
- ❑ Es desconfiado
- ❑ • Mira u oye cosas que no están allí (excepto los amigos imaginarios en niños más pequeños)
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ • Habla sobre la muerte
- ❑ • Pierde la memoria frecuentemente
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Otros:
¿Tiende este niño a tener accidentes? ¿Hay alguna situación que le esté causando a su familia tensión en particular? ¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí. ¿En que forma? ¿Cuando? ¿Tipo de tratamiento?, etc.

• ¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

TDH/OLS/6-396/11-96

7.20 Mental Health Interview Tool/Referral Form (Ages 10 to 12 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Ages 10 to 12

Date: _____

*Both child and parent will be able to provide information, and it is important to incorporate the child into the interview process. In each section, a sample question is directed toward the parent. To the extent possible, elicit the child's perception of the parent's response with a question such as "Do you agree with what your Mom is saying?" It may be useful to allow time for discussion with the caregiver alone. The child should be interviewed alone when asking questions about sexual or physical abuse and about substance abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Does your child (do you) have feelings that concern you or seem out of the ordinary for age?
restless
sad or cries easily
guilty
irritable or angers easily
sullen
fearful or anxious
bored

Behavior:

Does your child (do you) behave in ways that seem out of the ordinary for age?
problems in school
* threatens or harms other children or animals
lacks interest in things s/he used to enjoy
engages in sexual play with others, toys, animals
* destroys possessions or other property
steals
refuses to talk
* sets fires
overactive
* has been in trouble with the police
* self-destructive

Social Interaction:

Do you have any concerns about how your child (you) gets along with family members, other adults or children?
prefers to be alone
difficulty making and keeping friends
defiant, a discipline problem
aggressive
argues excessively
refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for your child (you)?
* frequently confused
daydreams excessively
distracted, doesn't pay attention
mistrustful
* sees or hears things that are not there
blames others for his/her misdeeds or thoughts
* talks about death or suicide
* frequent memory loss
* bizarre thoughts
schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?
lacks energy
uses laxatives
vomits frequently
food refusal, secretive eating
frequent stomachaches
headaches
excessive weight loss or gain
sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Is the child (are you) accident-prone?
Are there any situations which are causing your family particular stress?
Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.
* Is this child at risk for out-of-home placement because of behavior problems?
Has this child (have you) been treated for mental health problems or substance abuse?

Substance Abuse Questions: (May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)
__ has been identified as a problem

Comments:

Signature/Title: _____

7.21 Mental Health Interview Tool/Referral Form (Ages 10 to 12 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y Formulario para Tratamiento con un Especialista

De 10 a 12 Años de Edad

Nombre del Niño: _____
Fecha de Nacimiento: _____
Fecha: _____

Ambos, el niño y los padres podrán proveer información, y es importante incorporar al niño en la entrevista. En cada sección, se le hace una pregunta ejemplar a los padres. Obtenga, lo mejor que pueda, la percepción del niño sobre la respuesta de sus padres con una pregunta como "¿Estás de acuerdo con lo que dice tu mamá?" Sería conveniente dedicar tiempo para hablar solamente con el tutor del niño. Se debe entrevistar al niño solo cuando se hagan preguntas sobre el abuso sexual o físico y sobre el abuso de sustancias como las drogas y las bebidas alcohólicas. Marque las características que le preocupan. • La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.

Sentimientos:
¿Tiene su niño (tienes) sentimientos que le (te) preocupan o que parezcan extraños para su (tu) edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Tiene miedo o está ansioso
- ❑ Se aburre

Comportamiento:
¿Se (Te) comporta(s) de una manera que parecen extrañas para su (tu) edad?

- ❑ Problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a animales
- ❑ No tiene interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales o con los demás
- ❑ • Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ • Enciende fuegos
- ❑ Es demasiado activo
- ❑ • Ha tenido problemas con la policía
- ❑ • Tiene un comportamiento de autodestrucción

Interacción Sociales:
¿Se (te) preocupa(s) sobre cómo se (te) lleva(s) su niño con los miembros de la familia? ¿Con otros adultos? ¿O niños?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer o tener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:
¿Ha(s) notado si alguno de los siguientes es un problema para su niño (ti)?

- ❑ • Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ • Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ • Habla sobre la muerte o el suicidio
- ❑ • Pierde la memoria frecuentemente
- ❑ • Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:
¿Le (te) preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, se despierta seguido por la noche

Otros
¿Es este niño (Eres) propenso a tener accidentes? ¿Hay alguna situación que le esté causando a su (tu) familia tensión en particular? ¿Ha sido este niño (Has sido tu) o sus (tus) padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí, ¿Que tipo?, ¿Cuándo?, ¿Tipo de tratamiento? etc.

- ❑ • ¿Corre el riesgo este niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?
- ❑ Ha sido este niño tratado por problemas de salud mental o por el abuso de sustancias como drogas y bebidas alcohólicas?

Preguntas Sobre el Abuso de Sustancias: (Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el abuso de sustancias como drogas y bebidas alcohólicas.)

- ❑ Ha sido identificado como un problema

Comentarios:
Firma/Título de su puesto: _____

TDH/OLS/6-397/11-96

7.22 Mental Health Interview Tool/Referral Form (Ages 13 to 21 Years)

Mental Health Interview Tool/Referral Form

Child's Name: _____

Birth Date: _____

Ages 13 to 21

Date: _____

*You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Do you (does your teen) have feelings that concern you or seem out of the ordinary for your (their) age?
restless
sad or cries easily
guilty
irritable or angers easily
sullen
fearful or anxious
bored

Behavior:

Do you (does your child) behave in ways that seem out of the ordinary for your (their) age?
problems in school or at work
* threatens or harms other children or animals
lacks interest in things s/he used to enjoy
engages in sexual play with others, toys, animals
* destroys possessions or other property
steals
refuses to talk
* sets fires
overactive
* has been in trouble with the police
* self-destructive

Social Interaction:

Do you have any concerns about how (you) your child gets along with family members, other adults, or peers?
prefers to be alone
difficulty making and keeping friends
defiant, a discipline problem
aggressive
argues excessively
refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for you (your child)?
* frequently confused
daydreams excessively
distracted, doesn't pay attention
mistrustful
* sees or hears things that are not there
blames others for his/her misdeeds or thoughts
* talks about death or suicide
* frequent memory loss
* bizarre thoughts
schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?
lacks energy
uses laxatives
vomits frequently
food refusal, secretive eating
frequent stomachaches
headaches
excessive weight loss or gain
sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Are you (is the child) accident-prone?
Are there any situations which are causing your family particular stress?
Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.
* Are you (is this child) at risk for out-of-home placement because of behavior problems?
Have you (has this child) been treated for mental health problems or substance abuse?

Substance Abuse Questions: (May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)
__ has been identified as a problem

Comments:

Signature/Title: _____

7.23 Mental Health Interview Tool/Referral Form (Ages 13 to 21 Years) (Spanish)

Instrumento para la Entrevista sobre la Salud Mental/
Formulario para Tratamiento con un Especialista

De 13 a 21 Años

Nombre del Adolescente: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Usted puede empezar con una entrevista con ambos el tutor y el adolescente. Es preferible que entreviste al adolescente primero. Marque las características que le preocupen.* ● *La presencia de alguno de estos síntomas o comportamientos puede indicar que el adolescente está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:
¿Tiene su adolescente sentimientos que le preocupan o que le parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo o ansiedad
- ❑ Se aburre

Comportamiento:
¿Se comporta su adolescente de una manera que parece extraña para su edad?

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ ● Amenaza o lastima a otros niños o a animales
- ❑ No le interesan las cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás,
- ❑ ● Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ ● Provoca incendios
- ❑ Es demasiado activo
- ❑ ● Ha tenido problemas con la policía
- ❑ ● Tiene un comportamiento de autodestrucción

Interacciones Sociales:
¿Le preocupa cómo se lleva su adolescente con los miembros de la familia?
¿con otros adultos? ¿con su grupo social?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:
¿Ha notado si alguno de los siguientes es un problema para su adolescente?

- ❑ ● Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ ● Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo malo que hizo o por sus pensamientos
- ❑ ● Habla sobre la muerte o el suicidio
- ❑ ● Frecuentemente pierde la memoria
- ❑ ● Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:
¿Le preocupan algunas de las siguientes señales físicas? ¿Han sido evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come en secreto
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado peso excesivamente
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, frecuentemente camina en la noche

Otros:
¿Tiende a tener accidentes? ¿Hay alguna situación que le esté causando a su familia cierta tensión? ¿Ha sido es adolescente o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma? ¿cuándo? ¿tipo de tratamiento?, etc..
● ¿Corre el riesgo de ser llevado a otro lugar fuera de casa por problemas de comportamiento?
¿Ha sido tratado por problemas de la salud mental o por el abuso de sustancias como bebidas alcohólicas o drogas?

Preguntas sobre el abuso de sustancias: *(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el uso de sustancias.)*

- ❑ El abuso de sustancias como bebidas alcohólicas y drogas ha sido identificado como un problema.

Comentario:

Firma/Título del puesto: _____

TDH/OLS/6-398/11-96

7.24 Mental Health Parent Questionnaire (Ages Birth to 2 Years) (2 pages)

Mental Health Parent Questionnaire

Ages Birth to 2 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings

Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Fearful	❑ Is irritable	❑ Fearful
❑ Cries too much	❑ Is angry	❑ Cries too little
❑ Cries too little	❑ Is sad	❑ Cries too much
	❑ Is sullen	

Behavior

Does your child do things that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Is overactive	❑ Is over-active	❑ Harms others
❑ Is listless (has little energy)	❑ Is listless (has little energy)	❑ Has temper tantrums often

Social Interaction

Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No
With other family members or adults? ❑ Yes ❑ No
With brothers and sisters? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Does not make eye contact or smile	❑ Does not make eye contact or smile	❑ Does not respond to you
❑ Stiffens and arches back		❑ Does not say any words yet
❑ Does not respond to you	❑ Clings to you too much	

Thinking

Do you think your child is as bright and thinks as clearly as others their age? ❑ Yes ❑ No

Infants	1 to 2 Years
❑ (>8 months) Does not point to or ask for things or try to make words	❑ Does not trust others
	❑ Has problems concentrating or paying attention

Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No
	Infants to 2 Years ❑ Is low weight or has a lot of weight ❑ Vomits (throws up) often ❑ Has eating problems (poor appetite, eats non-foods) ❑ Has sleeping problems (wakes a lot at night) ❑ Has little energy

Other	Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Did the mother of this child use drugs or alcohol during the pregnancy? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____ Signature: _____

Relation to patient: _____

7.25 Mental Health Questionnaire (Ages Birth to 2 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

De Recién Nacido a 2 Años de Edad

Nombre del Niño: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématico que tenga su bebé. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su bebé. Favor de marcar todas las características abajo que son ciertas para su bebé. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años	
❑ Siente miedo	❑ Es de mal carácter	❑ Siente miedo
❑ Llora mucho	❑ Es enojón	❑ Llora muy poco
❑ Llora muy poco	❑ Es triste	❑ Llora mucho
	❑ Es malhumorado	

COMPORTAMIENTO

¿Hace su bebé cosas que le preocupan o que parezcan extrañas para su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ Es demasiado activo	❑ Es demasiado activo
❑ Es indiferente (tiene poca energía)	❑ Es indiferente (tiene poca energía)
	❑ Lastima a otros
	❑ Hace berrinches frecuentemente

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su bebé con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus hermanos o hermanas? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ No ve a los ojos ni sonríe	❑ No ve a los ojos ni sonríe
❑ Se pone tieso y se dobla arqueando la espalda	❑ La mayoría del tiempo no se le despega
❑ No le responde	❑ No le responde
	❑ Todavía no dice ninguna palabra

PENSAMIENTOS

¿Piensa usted que su niño es tan inteligente y que piensa tan claramente como otros niños de su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ (>8 meses) No pide ni senala a las cosas o trata de decir palabras	❑ No le tiene confianza a otros
	❑ Tiene problemas para concentrarse y poner atención

PROBLEMAS FÍSICOS

¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No

Si usted piensa que su niño tiene un problema de salud, ¿lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

De recién nacidos a 2 Años

- ❑ Es de peso bajo o ha perdido mucho peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta mucho durante la noche)
- ❑ Tiene muy poca energía

OTROS

¿Hay algo que le esté causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma? _____ ¿Cuándo? _____ ❑ Sí ❑ No

¿Empezó el tratamiento? ❑ Sí ❑ No

¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño? ❑ Sí ❑ No

Comentarios: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha: _____ **Firma:** _____

Parentesco con el paciente: _____

BIRTH-2Y.MH2 (9-25-96)
TDH/OLS/6-399/10-96

7.26 Mental Health Parent Questionnaire (Ages 3 to 9 Years) (2 pages)

Mental Health Parent Questionnaire

Ages 3 to 9 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is overly guilty ❑ Lacks remorse	❑ Is irritable, angers or temper tantrums easily ❑ Is sullen ❑ Fearful

Behavior	Does your child do things that seem strange for their age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Plays sexual games with others, toys, animals ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is over-active ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No With other family members or adults? ❑ Yes ❑ No With playmates? ❑ Yes ❑ No	
	❑ Withdraws and does not look into peoples' eyes ❑ Clings to you too much ❑ Has a hard time making and keeping friends ❑ Is defiant, has a disciplinary problem ❑ Severe or frequent tantrums	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school ❑ Prefers to be alone

Thinking	Are any of these a problem for your child? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death a lot ❑ Often cannot remember things

Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Has daytime wetting ❑ Soils pants ❑ Will not eat ❑ Has headaches ❑ Has lost or gained a lot of weight	❑ Has sleeping problems, nightmares, sleep-walking, early waking ❑ Vomits (throws up) often ❑ Has stomach aches often ❑ Lacks energy

Other	Is this child accident-prone?❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Is this child at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____Signature: _____

Relation to patient: _____

7.27 Mental Health Parent Questionnaire (Ages 3 to 9 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

De 3 a 9 Años de Edad

Nombre del Niño: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su niño. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que sean ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente muy culpable
- ❑ No tiene remordimiento
- ❑ Es de mal carácter, enojón o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Juega juegos sexuales con otros niño, juguetes, o animales
- ❑ Destruye cosas personales u ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus compañeros de juego? ❑ Sí ❑ No

- ❑ Se aleja y no ve a nadie a los ojos
- ❑ La mayoría del tiempo no se le despega
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Hace berrinches temperamentales fuertes o frecuentemente
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela
- ❑ Prefiere estar solo

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FÍSICOS

¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No

Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

❑ Se orina durante el día	❑ Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo
❑ Ensucia sus pantalones	❑ Se vomita frecuentemente
❑ No quiere comer	❑ Tiene dolores de estómago frecuentemente
❑ Tiene dolores de cabeza	❑ No tiene energía
❑ Ha perdido o aumentado mucho de peso	

OTROS

¿Es propenso este niño a tener accidentes? ❑ Sí ❑ No

¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si, sí ¿en qué forma? _____ ❑ Sí ❑ No

¿Cuándo? _____ ¿Empezó el tratamiento? ❑ Sí ❑ No

¿Corre el riesgo este niño de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha: _____ **Firma:** _____

Parentesco con el paciente: _____

3YR-9YR.MH2 (9-25-96)
TDH/OLS/6-400/10-96

7.28 Mental Health Parent Questionnaire (Ages 10 to 12 Years) (2 pages)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: _____

Birth Date: _____

Today's Date: _____

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child (you) may have a health problem, has he/she (have you) seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Lacks energy ❑ Uses laxatives ❑ Vomits (throws up) often ❑ Won't eat in front of people, sneaks food later ❑ Has stomach aches often	❑ Has headaches ❑ Has lost or gained a lot of weight ❑ Has sleeping problems, nightmares, sleep-walking, early waking, frequent night waking

Other	Is your child (you) accident-prone?❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Is this child (are you) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No Does your child (do you) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No Has this child (have you) been treated for mental health problems or substance abuse? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____Signature: _____

Relation to patient: _____

7.29 Mental Health Parent Questionnaire (Ages 10 to 12 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

De 10 a 12 Años de Edad

Nombre del Niño: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su hijo. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que son ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Es de mal carácter o se enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Se aburre

COMPORTAMIENTO

Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Participa en actividades sexuales
- ❑ Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con otros niños? ❑ Sí ❑ No

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte o del suicidio
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FÍSICOS

¿Se preocupa sobre los siguientes problemas físicos? ❑ Sí ❑ No

¿Si piensa que su niño tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No

- ❑ Le falta energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ No come delante de la gente, come después a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado mucho peso
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, despierta temprano, despierta seguido por la noche

OTROS

¿Es propenso a tener accidentes su niño? ❑ Sí ❑ No

¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha sido este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma? _____ ¿Cuándo? _____ ❑ Sí ❑ No

¿Empezó el tratamiento? ❑ Sí ❑ No

¿Corre este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

¿Toma bebidas alcohólicas o usa drogas su niño (incluyendo las de la calle y las que se venden sin receta)? ❑ Sí ❑ No

¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancia como las drogas y bebidas alcohólicas? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha: _____ **Firma:** _____

Parentesco con el paciente: _____

10-12YR..MH3 (9-25-96)
TDH/OLS/6-401/11-96

7.30 Mental Health Parent Questionnaire (Ages 13 to 21 Years) (2 pages)

Mental Health Parent Questionnaire

Ages 13 to 21 Years

Teen's Name: _____

Birth Date: _____

Today's Date: _____

To the Teen or Parent: *If you will assist us by filling out this form, we can help you find your (your teen's) strengths and any problem areas, too. Your answers will help us to know if we need to talk with you (your teen) and find out more about you (your teen). Please check all items below that are true for you (your teen). Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Do you (does your teen) show feelings that concern you or seem strange for your (their) age? ❑ Yes ❑ No	
	❑ Restless ❑ Sad or cry easily ❑ Guilty ❑ Irritable or angered easily	❑ Sullen ❑ Fearful ❑ Bored

Behavior	Do you (does your teen) often do things that seem strange for your (their) age? ❑ Yes ❑ No	
	❑ Have problems in school or work ❑ Threaten or harm other children or animals ❑ Lack interest in things you used to enjoy ❑ Is involved in sexual activity ❑ Destroy possessions or other property ❑ Steal	❑ Refuse to talk ❑ Set fires ❑ Over-active ❑ Hurt yourself ❑ Have been in trouble with the police

Social Interaction	Do you have any concerns about how you (your teen) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With peers? ❑ Yes ❑ No	
	❑ Prefer to be alone ❑ Have a hard time making and keeping friends ❑ Defiant, a disciplinary problem	❑ Pick on others a lot or often get into fights (hitting, etc.) ❑ Argue too much ❑ Will not go to school

Thinking	Are any of these a problem for you (your teen)? ❑ Yes ❑ No	
	❑ Frequently confused (does not understand what is going on) ❑ Daydream a lot ❑ Distracted, do not pay attention ❑ Have very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Do not trust others ❑ See or hear things that are not there ❑ Blame others for your misdeeds or thoughts ❑ Talk about death or suicide a lot ❑ Often cannot remember things

Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think you (your teen) may have a health problem, have you (has he/she) seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Lack energy ❑ Use laxatives ❑ Vomit (throw up) often ❑ Won't eat in front of people, sneak food later ❑ Have stomach aches often	❑ Have headaches ❑ Have lost or gained a lot of weight ❑ Have sleeping problems, nightmares, sleep-walking, early waking, frequent night waking

Other	Are you (is your teen) accident-prone?❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _____ When? _____ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Are you (is this teen) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No Do you (does your child) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No Have you (has this teen) been treated for mental health problems or substance abuse? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: _____Signature: _____

Relation to patient: _____

7.31 Mental Health Parent Questionnaire (Ages 13 to 21 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

De 13 a 21 Años de Edad

Nombre del Adolescente: _____
Fecha de Nacimiento: _____
Fecha: _____

Para los Padres: *Si nos ayuda llenando este formulario, podremos ayudarle a encontrar las áreas fuertes que tenga su hijo y también cualquier área problemático. Sus respuestas nos ayudarán a saber si necesitamos hablar con su hijo y saber más sobre él. Favor de marcar todas las características abajo que son ciertas para su hijo. Algunos de los comportamientos en las listas tal vez sean normales, pero si está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Se aburre

COMPORTAMIENTO

¿Hace su hijo cosas frecuentemente que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ Amenaza o lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Está envuelto en actividades sexuales
- ❑ Destruye casas personales u otras cosas ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Le preocupa cómo se lleva su hijo con los miembros de la familia? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con su grupo social? ❑ Sí ❑ No

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su hijo? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en su trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte o el suicidio
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FÍSICOS

¿Se preocupa por estas cosas? ❑ Sí ❑ No

Si piensa que su hijo tiene un problema de salud ¿ha ido a consultar con un médico o una enfermera por este problema. ❑ Sí ❑ No

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ No come delante de la gente, come después a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado mucho peso
- ❑ Tiene problemas para dormir, pesadillas, se despierta temprano, sonámbulo y frecuentemente despierta durante la noche

Otros

¿Es su hijo propenso a tener accidentes? ❑ Sí ❑ No

¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No

¿Ha sido su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? ❑ Sí ❑ No
Si sí, ¿en qué forma? _____ ¿Cuándo? _____
¿Empezó el tratamiento? ❑ Sí ❑ No

¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)? ❑ Sí ❑ No

¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o bebidas alcohólicas? ❑ Sí ❑ No

Comentario: (*Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.*)

Fecha: _____ **Firma:** _____

Parentesco con el paciente: _____

7.32 Hearing Screening Information

The Joint Committee on Infant Hearing (1994) developed the following criteria for infants at-risk. Any infant who has one or more of the following risk indicators is considered to be at increased risk for sensorineural hearing loss. The joint committee recommendation for those infants is that an auditory screen be done, preferably with Auditory Brainstem Response (ABR) or otoaccustic emissions testing at 40 dB nHL or less at each ear. This auditory screening is a benefit of the Texas Medicaid Program and should be billed on a HCFA-1500 claim form using procedure codes 5-92585 and 5-92587.

7.32.1 Risk Criteria: Neonates (birth - 28 days)

The risk factors that identify those neonates who are at-risk for sensorineural hearing loss include the following:

- Family history of congenital or delayed onset childhood sensorineural hearing loss
- Congenital infection known or suspected to be associated with sensorineural hearing loss such as toxoplasmosis, syphilis, rubella, cytomegalovirus, and herpes
- Craniofacial anomalies including morphologic abnormalities of the pinna and ear canal, absent philtrum, low hairline, etc.
- Birth weight less than 1500 grams (3.3 lbs.)
- Hyperbilirubinemia at a level exceeding indication for exchange transfusion
- Ototoxic medications including but not limited to the aminoglycosides used in multiple courses (e.g., gentamycin, tobramycin, kanamycin, streptomycin) and loop diuretics used in combination with aminoglycosides
- Bacterial meningitis
- Severe depression at birth, which may include infants with Apgar scores of 0 - 4 at one minute or 0 - 6 at five minutes
- Prolonged mechanical ventilation for a duration equal to or greater than five days (e.g., persistent pulmonary hypertension)
- Stigmata or other findings associated with a syndrome known to include sensorineural and/or conductive hearing loss (e.g., Waardenburg or Usher's Syndrome)

Additional risk factors associated with possible hearing loss after the first month of life include the following:

- Parent/caregiver concern regarding hearing, speech, language, or developmental delay
- Head trauma, associated with loss of consciousness or skull fracture
- Children with neurodegenerative disorders such as neurofibromatosis, myoclonic epilepsy, Werdnig-Hoffman disease, Tay-Sach's disease, infantile Gaucher's disease, Nieman-Pick disease, any metachromatic leukodystrophy, or any infantile demyelinating neuropathy
- Childhood infectious diseases known to be associated with sensorineural hearing loss (e.g., mumps, measles)
- Indicators associated with conductive hearing loss: recurrent or persistent otitis media with effusion for at least three months or anatomic deformities and other disorders that affect Eustachian tube function.

7.33 Hearing Checklist for Parents

Check Yes or No to Describe Your Child.

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	____	____	Does your baby get quiet for a moment when you talk to him/her?
	____	____	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	____	____	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	____	____	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	____	____	Does your baby stop and pay attention when you say “no” or call his/her name?
	____	____	Does your baby move his/her head around to try to find out where a new sound is coming from?
	____	____	Does your baby make strings of sounds (“ba ba ba, da da da”)?
10 to 15 months	____	____	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	____	____	Does your baby point to familiar objects if you ask (“dog,” “light”)?
16 to 24 months	____	____	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	____	____	Can your child go get familiar objects that are kept in a regular place if you ask him/her (“Get your shoes.”)?
25 to 36 months	____	____	Does your child answer different kinds of questions (“When...,” “Who...,” “What...”)?
	____	____	Does your child notice different sounds (telephone ringing, shouting, doorbell)?
If you answered “no” to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.			

Lista De Cotejo Para Padres

Marque si ó no para describir a su hijo(a)

Age 0 to 3 Yrs	Yes	No	
0 to 3 meses	____	____	¿Se pone calladito por unos instantes cuando le platica?
	____	____	¿Parece asustárce o se para de mover por unos instantes cuando se hacen ruidos fuertes de repente?
4 to 6 meses	____	____	¿Cambia o voltea la cabeza al sonido de su voz si no puedo veria?
7 to 9 meses	____	____	¿Se detiene y pone atención cuando usted le dice que ‘no’ o llama su nombre?
	____	____	¿Voltea la cabeza para diferentes lados para tratar de averiguar de dónde viene el sonido cuando oye un sonido nuevo?
	____	____	¿Platica series de sonidos (como “bababa”, “dadada”)?
10 to 15 meses	____	____	¿Le da jugetes o otros objetos (como la mamila) cuando usted se los pide sin que usted tenga que usar un gesto (alargando la mano, o señalando)?
	____	____	¿Señala objetos familiares (“perro”, “luz”) si usted le pregunta?
16 to 24 meses	____	____	¿Usa su voz la mayor parte del tiempo para avisarte de lo quiere o para comunicarse con usted?
	____	____	¿Puede taer objetos familiares que son guardados en lugar habitual (“trae tus zapatos”) si usted se los pide?
25 to 36 meses	____	____	¿Puede contestar diferentes tipos de preguntas (“cuándo...”, “quién...”, “qué”)?
	____	____	¿Se fija en diferentes sonidos (teléfono, gritos, timbre de la puerta)?
Si usted tiene alguna pregunta o inquietud acerca de la audición de su hijo(a) o si usted contestó ‘no’ a cualquier pregunta, informese con su doctor acerca de un exámen de audición para su bebé. Los bebés pueden ser examinados de la audición desde el dia de su nacimiento.			

7.34 Guidelines: Tuberculosis Skin Testing (2 pages)

TEXAS DEPARTMENT OF HEALTH
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Purpose:

The tuberculosis intradermal skin test is used to detect tuberculosis infection

- To detect infection, either past or present, with Mycobacterium tuberculosis.
- To serve as a diagnostic procedure in selected patients

Equipment:

- PPD (purified protein derivative) tuberculin antigen
- Tuberculin syringe
- Short, 3/8" 26 gauge needle
- Alcohol sponge

Procedures:

Nursing Action	Rationale/Amplification
1. Determine if patient has ever had BCG vaccine, a previously positive skin test, recent viral disease or immunization with a live virus vaccine within the last 30 days, immunosuppression by disease, drugs, or steroids.	1. A history of BCG vaccine should be documented but does not cancel the need for tuberculin skin testing.
2. Draw up 0.1 ml of PPD-tuberculin into tuberculin syringe. Each 0.1 ml should contain 5 TU (tuberculin units of PPD tuberculin).	2. Use immediately to avoid absorption into the plastic/glass syringe.
3. Cleanse the skin of the volar (palm side) surface of the **left** arm with alcohol. Allow to dry.	3. An intradermal test may be applied at any site but the use of the left arm is practiced universally to facilitate identifying the location of the injection site by the health care worker who reads the test. If the test is applied at another site, document the exact site of injection
4. Stretch the skin taut.	4. Facilitates the introduction of the needle
5. Hold the tuberculin syringe close to the skin, bevel up, so that the hub of the needle is introduced.	5. Holding the syringe in this way will reduce the needle angle at the skin surface, promoting the correct entry for a proper intradermal injection
6. Inject the tuberculin into the superficial layer of the skin to form a wheal 6mm to 10 mm in diameter	6. If no wheal appears (because the injection was made too deep, or the wheal is smaller than 6mm (because the needle was not under the skin and part of the antigen leaked on the outer surface of the skin, reapply test at another site at least five centimeters (two inches) from the original site

To Read the Test	
1. Read the test within 48-72 hours.	1. Tuberculin skin tests are tests of delayed hypersensitivity. In certain circumstances, **a skin test may be read up to 96 hours after the test is applied.**
2. Have a good light available. Flex the forearm slightly at the elbow.	
3. Inspect for the presence of induration. Inspect from a side view against the light. Inspect by direct light	3. Induration refers to hardening or thickening of tissues.
4. Palpate: lightly rub the fingers across the injection site from the area of normal skin to the area of induration. Outline the diameter of induration.	
5. Measure the maximum transverse diameter of induration (not erythema) in millimeters with a flexible ruler.	5. Erythema (redness) without induration is generally considered to be of no significance.

TEXAS DEPARTMENT OF HEALTH
GUIDELINES: TUBERCULOSIS SKIN TESTING
(TPD/MANTOUX)

Procedures

Interpretation

1 Negative reaction: An induration of 0- < 5mm

1. This shows either a lack of tuberculin sensitivity or a low grade sensitivity that most likely is not caused by M. tuberculosis. A negative test does not rule out the presence of tuberculosis. Because of the possibility of a false negative result, the tuberculin skin test should never be used to exclude the possibility of active disease among persons for whom the diagnosis is being considered.

2 Positive Reaction

a An induration of 5mm or more is considered to be positive in individuals who are:

1) contacts to a case of tuberculosis,
2) HIV positive, or
3) individuals with radiological findings consistent with old, healed tuberculosis
4) IVDU with unknown HIV status.

2a. A positive reaction indicates that a patient has had contact with tubercule bacillus. It does not necessarily mean that active disease is present in the lung, however further evaluation is required. Individuals who are in close contact with persons with active tuberculosis and who have reactions ≥ 5mm should be considered positive and receive preventive therapy once active disease is ruled out.

b An induration of 10mm or more is considered to be positive in individuals who are:

1) at risk for tuberculosis (Foreign born individuals from countries with a high prevalence of tuberculosis),
2) intravenous drug users known to be HIV negative,
3) the medically under-served including high risk ethnic and racial minority populations,
4) residents of long-term care facilities such as correctional institutions, nursing homes, or mental institutions,
5) persons with medical conditions which have been reported to increase the risk of tuberculosis such as silicosis, being 10% under ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroids and other immunosuppressive therapy, and some hematologic disorders and malignancies,
6) health care workers who provide services to any of the high risk groups.

2b. Individuals with skin test results of ≥ 10mm should be considered for preventive therapy once disease is ruled out.

c An induration of 15mm is considered to be positive in individuals with no risk factor for tuberculosis.

Note

A tuberculin converter is a person whose tuberculin reaction increases by ≥ 10 mm in individuals < 35 years of age, or increases by ≥ 15 mm in individuals ≥ 35 years of age.

Documentation

1. Record name of antigen, strength of antigen, lot number, date of testing, and date of reading.
2. Record site of application of test if applied at site other than the left volar surface.
3. Record the size of induration.

References

1. Guidelines: Tuberculin skin test. The Lippincott manual of nursing practice. 3rd ed. p. 814. J. Lippincott Co. Philadelphia, London.
2. Tuberculin reaction size and five consecutive days. (1955) Bulletin, world health organization, 12 pp. 189-196.
3. The tuberculin skin test. (1981) American Thoracic Society, medical section of American Lung Association. p. 1-6.
4. [illegible] on Tuberculosis (1990) Centers for Disease Control. p. 13-35.

7.35 Tuberculosis (TB) Screening and Education Tool

This screening tool for TB exposure risk is to be used annually to determine the need for tuberculin skin testing. The screening tool is not necessary at visits for which tuberculin skin testing is required. Refer to "Tuberculosis Testing" on page 3-19 for more information.

The questions in this screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child's community may need to be added.

- If all the answers are unqualified negatives, the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "yes" or "I don't know," the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of "yes" or "I don't know" prompted a skin test which was negative, the skin test **may** not have to be repeated annually.
- The decision to skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- BCG vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not) should be re-evaluated at least annually by a physician for signs and symptoms of TB).

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB,
- A chest x-ray to rule out active disease,
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present,
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present*,
- A report to the local health authority for investigation to find the source of the infection.

Limit 10 copies. This tool is available in English and Spanish from the Bureau of Children and Health, Texas Department of Health. You may photocopy the screening and education tool on the following pages. For assistance in locating a specialist, contact the TB program at 512-458-7447.

7.36 TB Questionnaire

This questionnaire is about tuberculosis. Tuberculosis can be transmitted to children by adults who live with or spend a great deal of time with them. Tuberculosis is transmitted by a person with tuberculosis to another person through airborne droplets that are coughed or sneezed into the air and breathed in by the child. This transmission of infection is more likely to occur when the child and the infectious person spend a lot of time together in a closed environment, like a small room, a car, or other similar situations.

Adults who have tuberculosis will often have the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills, and night sweats.

Children with tuberculosis frequently do not have symptoms.

A person can have a tuberculosis infection and not have active tuberculosis.

- Not everyone who coughs has tuberculosis.
- TB can cause (low grade) fever of long duration, unexplained weight loss, failure to maintain adequate growth in children, weakness, chest pain, a bad cough, hoarseness, and/or coughing up blood.
- Tuberculosis is preventable and treatable.
- Children with active TB often do not show signs of illness. Infants are more likely to have symptoms.
- We need your help to find out if your child has been exposed to tuberculosis.

Since your child's last skin test:	Yes	No	I Don't Know
Has anyone in your family had tuberculosis?			
Do you know of any situation where your child was around an adult who has been diagnosed or suspected as having TB?			
Was your child born in or has your child visited a foreign country where there is a lot of TB?			
If yes, which country/countries?			
TB can cause fever of long duration, unexplained weight loss, weakness, chest pain, a bad cough, hoarseness or coughing up blood. Has your child been around anyone who has these problems?			
Has your child had any of these problems?			
To your knowledge, has your child had contact with anyone who is/has been an intravenous (IV) drug user?			
HIV-infected?			
In jail/prison?			
Recently moved to the US from a foreign country?			

7.37 Cuestionario Para la Detección de Tuberculosis

Este es un cuestionario sobre tuberculosis. Los adultos que viven o que pasan mucho tiempo con ninos les pueden contagiar la tuberculosis. Esta enfermedad se trasmite de una persona con tuberculosis a otra persona a traves de gotitas que se tosen o se estornudan en el aire, y que el niño aspira. Es mas facil que ocurra esta trasmision de la infeccion cuando el nino y la persona infectada pasan mucho timepo juntos en un medio cerrado, como un cuarto pequeno, un carro, u otras situactiones similares.

Los adultos que tienen tuberculosis a menudo van a tener los sintomas siguientes: tos que dura mas de dos semanas, perfida del apetito, perdida de diez libras o mas en un periodo de tiempo corto, fiebre, escalofrios, y sudores de noche.

Los ninos con tuberculosis frecuentemente no tienen sintomas.

Una persona puede estar infectada con tuberculosis, pero no tener la enfermedad activa.

- No todas las personas que tosen tienen tuberculosis.
- La tuberculosis puede causar una fiebre (baja) que dura mucho tiempo, una pérdida de peso que no se puede explicar, que los ninos no crezcan como deben, debilidad, dolor en el pecho, una tos fuerte, estar ronco, y/o toser sangre.
- La tuberculosis puede prevenirse y tratarse.
- Los niños con tuberculosis activa muchas veces no parecen enfermos, pero es más probable que los bebés tengan síntomas.
- Necesitamos su ayuda para saber si su niño ha estado expuesto a la tuberculosis.

Desde la ultima prueba de la tuberculosis en la piel de su hijo o hija:	Sí	No	No sé
¿Alguien en su familia tuvo tuberculosis?			
¿Usted sabe si hubo casos en que su hijo/hija estuvo con un adulto diagnosticado con TB, o que se sospecha tiene esta enfermedad?			
¿Su hijo/hija nacio o estuvo en us pais donde hay mucha TB?			
¿Si contesto "sí", cual fue el país o los paises?			
¿La TB puede causar fiebre que dura mucho tiempo, perdida de peso que no puede explicarse, debilidad, dolor en el pecho, tos fuerte, ronquera o tos con sangre. ¿Su hijo o hija ha estado con alguien que tiene estos problemas?			
¿Por lo que usted sabe, su hijo o hija ha estado en contact con alguien que usa o ha usado drogas intravenosas?			
¿que está infectado con HIV?			
¿que esta o estuvo en la cárcel?			
¿que recientement se mudó de otro pais a los Estados Unidos?			

7.38 Screening Schedule for High-Blood Leads

SCREENING SCHEDULE FOR HIGH BLOOD LEADS

age of child	may use primary parent questionnaire	may use abbreviated parent questionnaire	blood lead test required	conditions
6 mths.	yes			
12 mths.			yes	
18 mths.	yes			
24 mths.			yes	
3, 4, 5, and 6 years	yes, if any answer on abbreviated parent questionnaire is "yes"	yes		if child has no record of a blood lead test, child MUST have an actual blood lead test

NOTE: A "yes" or "I don't know" answer to any question on any parent questionnaire indicates that a blood lead test should be administered.

7.39 THSteps Primary Parent Risk Assessment for Lead Exposure Questionnaire

Patient's Name: _____
Date Questionnaire Administered: _____

Texas Health Steps

PRIMARY PARENT QUESTIONNAIRE

SCREENING QUESTIONS FOR A CHILD WHO HAS NEVER HAD A HIGH BLOOD LEAD

This questionnaire is about lead. Lead is a dangerous substance that sometimes gets into children's bodies. It can make them sick and affect their behavior and ability to learn. Answers to these questions will help the doctor see if your child may have been exposed to lead. If your child has been exposed to lead, the doctor will need to do a blood test. The test may show that the child has lead in his/her blood or it may show that your child is fine. Even if your child does have a high blood lead, the doctor can tell you things that you can do to help your child be healthy. If any of these questions are confusing, ask the doctor or nurse to help you with them.

1) Do you live in or often visit a house that was probably built before 1978?
YES **NO** **I DON'T KNOW**

2) Does your child live in or often visit a house that is being painted, remodeled, or having the paint scraped or sanded?
YES **NO** **I DON'T KNOW**

3) Does your child eat or chew on non-food things like paint chips or dirt?
YES **NO** **I DON'T KNOW**

4) Have any other members of the family or your child's playmates had high blood leads as far as you know?
YES **NO** **I DON'T KNOW**

5) Does you family live near or does your child play near any of these (circle the ones that apply):
smelter
hazardous waste site
lead industry
place where batteries are manufactured or repaired
house construction site
heavily traveled major highway
place where cars are abandoned or repaired?

6) Do you give your child, or have you ever given your child, any of these products from another country:

MEDICINES like greta or azarcon for empacho, alarcon, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, or rueda?
YES **NO** **I DON'T KNOW**

NUTRITIONAL PILLS OTHER THAN VITAMINS?
YES **NO** **I DON'T KNOW**

7) Does anyone living in your house work at a place where any of these things happen or have a hobby that involves these things (circle the ones that apply):
radiator repair
lead industry
welding
battery manufacture or repair
house construction or repair
smelting
chemical preparation
making pottery
going to a firing range
stained glass with lead solder
brass/copper foundry
valve and pip fittings
bridge, tunnel and elevated highway construction
industrial machinery and equipment
re-loading bullets or making fishing weights
refinishing furniture
burning lead-painted wood
automotive repair shop

Does anybody that your child spends a lot of time with (outside of your home) do any of these things or work at a place where these things are done?
YES **NO** **I DON'T KNOW**

8) Is imported or glazed pottery, or a Mexican bean pot, used to cook or store your food?
YES **NO** **I DON'T KNOW**

9) Does your child eat foods canned or packaged (such as candy) outside the U.S.?
YES **NO** **I DON'T KNOW**

7.40 THSteps Primary Parent Risk Assessment for Lead Exposure Questionnaire (2 Pages) (Spanish)

Nombre del Paciente: _____

Fecha de Administración del Cuestionario: _____

Pasos para la Salud en Texas

CUESTIONARIO PRIMARIO PARA LOS PADRES

PREGUNTAS DE DETECCIÓN PARA NIÑOS QUE NUNCA HAN TENIDO ALTOS NIVELES DE PLOMO EN LA SANGRE

Este cuestionario es sobre el plomo. El plomo es una substancia dañina que algunas veces se introduce en el cuerpo de los niños. Puede enfermarlos y afectar su comportamiento, así como su capacidad de aprendizaje. Las respuestas a estas preguntas ayudarán al médico a saber si su hijo(a) puede haber estado expuesto al plomo. Si su hijo(a) ha estado expuesto al plomo, el médico necesitará hacerle una prueba de sangre. La prueba puede mostrar si su hijo(a) tiene plomo en la sangre o puede indicar que su hijo(a) esta bien. Aún si su hijo(a) tiene altos niveles de plomo en la sangre, el médico puede darle indicaciones sobre lo que puede hacer para ayudar a su hijo(a) a estar sano. Si algunas de las preguntas son confusas, pregúntele al médico o a la enfermera que le ayuden.

1) ¿Vive usted en o visita frecuentemente alguna casa que **probablemente** haya sido construida antes de 1978?

SÍ ❑ **NO** ❑ **NO LO SE** ❑

2) ¿Vive su hijo(a) en o visita frecuentemente una casa que está siendo pintada, remodelada, o que están pelando o lijando la pintura?

SÍ ❑ **NO** ❑ **NO LO SE** ❑

3) ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura u objetos sucios?

SÍ ❑ **NO** ❑ **NO LO SE** ❑

4) ¿Algún otro miembro de la familia o compañeritos de juego tienen altos niveles de plomo en la sangre, que usted esté enterada?

SÍ ❑ **NO** ❑ **NO LO SE** ❑

5) ¿Su familia vive cerca o su hijo(a) juega cerca de alguno de los siguientes lugares? (encierre en un **círculo** la respuesta)

fundición
sitio de desperdicios peligrosos
industria de plomo
lugar donde se fabrican o reparan baterías
sitio de construcción de una casa
autopista con mucho tránsito
lugar donde los autos son reparados o abandonados?

6) ¿Le da usted o le ha dado alguna vez a su hijo(a) alguno de los siguientes productos provenientes de otro país?

- MEDICINAS tales como greta, o azarcón para el empacho, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, o rueda?

  SÍ ❑ **NO ❑** **NO LO SE ❑**

- PÍLDORAS NUTRICIONALES QUE NO SEAN VITAMINAS

  SÍ ❑ **NO ❑** **NO LO SE ❑**

7) ¿Hay alguna persona viviendo en su casa que trabaje en un lugar donde se realice alguna de las cosas que describimos a continuación o que tengan un pasatiempo que involucre alguna de los siguientes? (encierre en un **círculo** la respuesta):

reparación de radiador
industria del plomo
soldadura
fabricación y reparación de baterías
construcción o reparación de casas
fundición (de metales)
preparación de químicos
fabricación de cerámica
ir a un campo de tiro
fabricación de vitrales con soldadura de plomo
fundición de latón /cobre
partes sueltas para tubos de cañerías y válvulas
construcción de una autopista elevada, puente, túnel
equipo y maquinaria industrial
recargo de balas de armas de fuego o fabricación de pesas para pescar
terminado de muebles
quema de madera pintada con plomo
taller mecánico para autos

¿Alguna persona con quien su hijo pasa largo tiempo, hace alguna de las siguientes cosas o trabaja en lugares (fuera de la casa) donde se realizan las actividades antes mencionadas?

SÍ ❑ **NO ❑** **NO LO SE ❑**

8) ¿Usa usted productos de cerámica importada o con recubrimiento de barniz, o una olla para frijoles de México, para cocinar o para guardar su comida?

SÍ ❑ **NO ❑** **NO LO SE ❑**

9) ¿Come su hijo(a) productos enlatados o empacados (tales como dulces) fuera de los Estados Unidos?

SÍ ❑ **NO ❑** **NO LO SE ❑**

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7.41 Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure

Patient's Name: _____

Date Questionnaire Administered: _____

ABBREVIATED PARENT QUESTIONNAIRE
RISK ASSESSMENT FOR LEAD EXPOSURE

You may use the Abbreviated Parent Questionnaire for lead screening:

1. At the patient's 3, 4, 5, and 6 year visits.
2. If the patient has never had an elevated blood lead level.
3. If the parent answered "no" to all questions on the primary lead screening parent questionnaire at the 6-month and 18-month visits.

If the parent answers "yes" to any of the questions below, you must administer the Primary Parent Questionnaire or give the child a blood lead test.

1. Has your residence changed since your child's last lead screen?

   YES ❑ NO ❑

2. Has your child changed babysitters or daycare centers since the last lead screen?

   YES ❑ NO ❑

3. Has anyone in your home changed jobs since your child's last lead screen?

   YES ❑ NO ❑

4. Has anyone in your home been:

   - re-loading bullets
   - making pottery
   - making stained glass
   - refinishing furniture
   - working on autos
   - going to a firing range

5. Since the last lead screen, has your child been around any home remodeling or houses that are having the paint removed?

   YES ❑ NO ❑

6. Are you giving your child medications produced outside the United States, like Greta or Azarcon?

   YES ❑ NO ❑

7.42 Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure (Spanish)

Usted puede usar el Cuestionario Abreviado para los Padres para la detección de Plomo en la sangre:

1. **En las visitas anuales 3, 4, 5, y 6 del paciente.**
2. **Si el paciente nunca ha tenido un elevado nivel de plomo en la sangre.**
3. **Si los padres contestaron "no" a todas las preguntas del cuestionario para los padres para la detección primaria de plomo durante las visitas de los 6 y 18 meses.**

Si los padres contestan "sí" a cualquiera de las preguntas que siguen, usted debe administrar el Cuestionario Primario para Padres o hacerle al niño un examen para la detección de plomo en la sangre.

Texas Department of Health
Departamento de Salud de Texas

Nombre del paciente: _____

Fecha de Administración del Cuestionario: _____

CUESTIONARIO ABREVIADO PARA LOS PADRES
EVALUACIÓN DE RIESGO POR EXPOSICIÓN AL PLOMO

1. ¿Se ha cambiado de domicilio desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ **NO** ❑

2. ¿Ha cambiado a su hijo(a) de niñera o de guardería desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ **NO** ❑

3. ¿Alguna de las personas que vive en su casa ha cambiado de trabajo desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ **NO** ❑

   Si contestó sí, escriba el nombre del nuevo trabajo: _____

4. Alguna persona en su casa ha estado:
   - recargando balas en armas
   - trabajando con cerámica
   - trabajando con vitrales
   - terminado de muebles
   - trabajando en automóviles
   - yendo a un campo de tiro

   SÍ ❑ **NO** ❑

5. ¿Desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre ha estado él en cualquier casa que se esté remodelando o casas donde estén quitando la pintura?

   SÍ ❑ **NO** ❑

6. ¿Le está dando a su hijo(a) alguna medicación producida fuera de los Estados Unidos, tales como Greta o Azarcón?

   SÍ ❑ **NO** ❑

02/97

Card

ıst Name (PLEASE PRINT LEGIBLY)

rst Name MI

reet Address

ty Zip code

tient I.D. No._____

S.N. _____ - _____ - _____

ıte of Birth _____/_____/_____ Age _____

edicaid / Medicare Number

inic Code :_____

inic Type ???FP AH CD EPSDT

inic Name and Address: New Address? ❑

ail report to: (if different from above)

FOR CLINIC USE ONLY

Tests (circle) Cytology Gonorrhea/Chlamydia
(required specimen) (glass slide) (special ?? in transparent medium)

Source of
Cytology Specimen: Cervix Vagina

Other:

Cyto?? Yes No Cervical Biopsy? Yes No

Date of Smear _____/_____/_____ Date of LMP _____/_____/_____

DATE

CLINICAL HISTORY: Post Menopausal Yes No
Pregnant Yes No Post Partum Yes No
I.U.D. Yes No Hormones Yes No
Cryotherapy Yes No Laser Yes No
Hysterectomy Yes No Radiation Yes No
Prior Abnormal Yes No Dr. and Lab No. _____

_____

Race: W H B AI AS Other:

History of physical findings: _____

I, _____,authorize the S.A.S.C.H. to release to _____ any cytologic or biologic reports, slides, and/or blocks at their request.

I further assign all benefits payable under my insurance coverage through _____ to the TDH for these services.

Patient signature | Policy number | Date

Witness signature | Printed name | Date

Signature of policy holder (If different from patient) | Printed name | Date

REQUIRED INFORMATION

LABORATORY FOR WOMEN'S AND CHILDREN'S HEALTH
SAN ANTONIO STATE CHEST HOSPITAL
CERVICAL CYTOLOGY CANCER LABORATORY
2303 S.E. Military Drive
San Antonio, TX 78223
(210) 534-8857 x361 FAX (210)534-8857 827-8361
TxAn 827-8361 TxAn FAX 827-8266

FOR LAB USE ONLY

??? Number:
Condition on Receipt: ❑ Adequate ❑ Broken in Transit ____% Loss
❑OTHER:

Tech:_____ Q.C. Tech_____ Pathologist _____

STATEMENT OF SPECIMEN ADEQUACY

Satisfactory ❑ ❑ ❑	**Limited by** ❑ ❑ ❑	**Unsat** ❑ ❑ ❑
A ❑ ❑ ❑ Yes ECs	B ❑ ❑ ❑ ?? Cell	E ❑ ❑ ❑ Blood
G ❑ ❑ ❑ No ECs	C ❑ ❑ ❑ Poor fix	F ❑ ❑ ❑ Cytol
❑ ❑ ❑ NA ECs	D ❑ ❑ ❑ ???	H ❑ ❑ ❑ Thick

BENIGN CELLULAR CHANGES

1 ❑ ❑ ❑ WBCs	5 ❑ ❑ ❑ Yeast	9 ❑ ❑ ❑ R & R
2 ❑ ❑ ❑ Inf Chng	6 ❑ ❑ ❑ S. Flora	10 ❑ ❑ ❑ Atrophy
3 ❑ ❑ ❑ Bacteria	7 ❑ ❑ ❑ Herpes	11 ❑ ❑ ❑ Radiation
4 ❑ ❑ ❑ Trich	8 ❑ ❑ ❑ ????	12 ❑ ❑ ❑ EC vaginal

Comment:

EPITHELIAL ABNORMALITIES

1 ❑ ❑ ❑ Atypical Squamous Cells	J ❑ ❑ ❑ Probably reactive
	K ❑ ❑ ❑ s/o Low Grade SIL
2 ❑ ❑ ❑ Low Grade SIL	A ❑ ❑ ❑ HPV changes
	B ❑ ❑ ❑ Mild dysplaysia
3 ❑ ❑ ❑ High Grade SIL	C ❑ ❑ ❑ Moderate dysplasia
	D ❑ ❑ ❑ Severe dysplasia/CIS
4 ❑ ❑ ❑ Atypical Glandular Cells	
e ❑ ❑ ❑ Endometrial	5 ❑ ❑ ❑ EMs out of phase
f ❑ ❑ ❑ Endocervical	6 ❑ ❑ ❑ EMs in PMP patient
g ❑ ❑ ❑ Not specified	7 ❑ ❑ ❑ EMs w/o history

Comment:

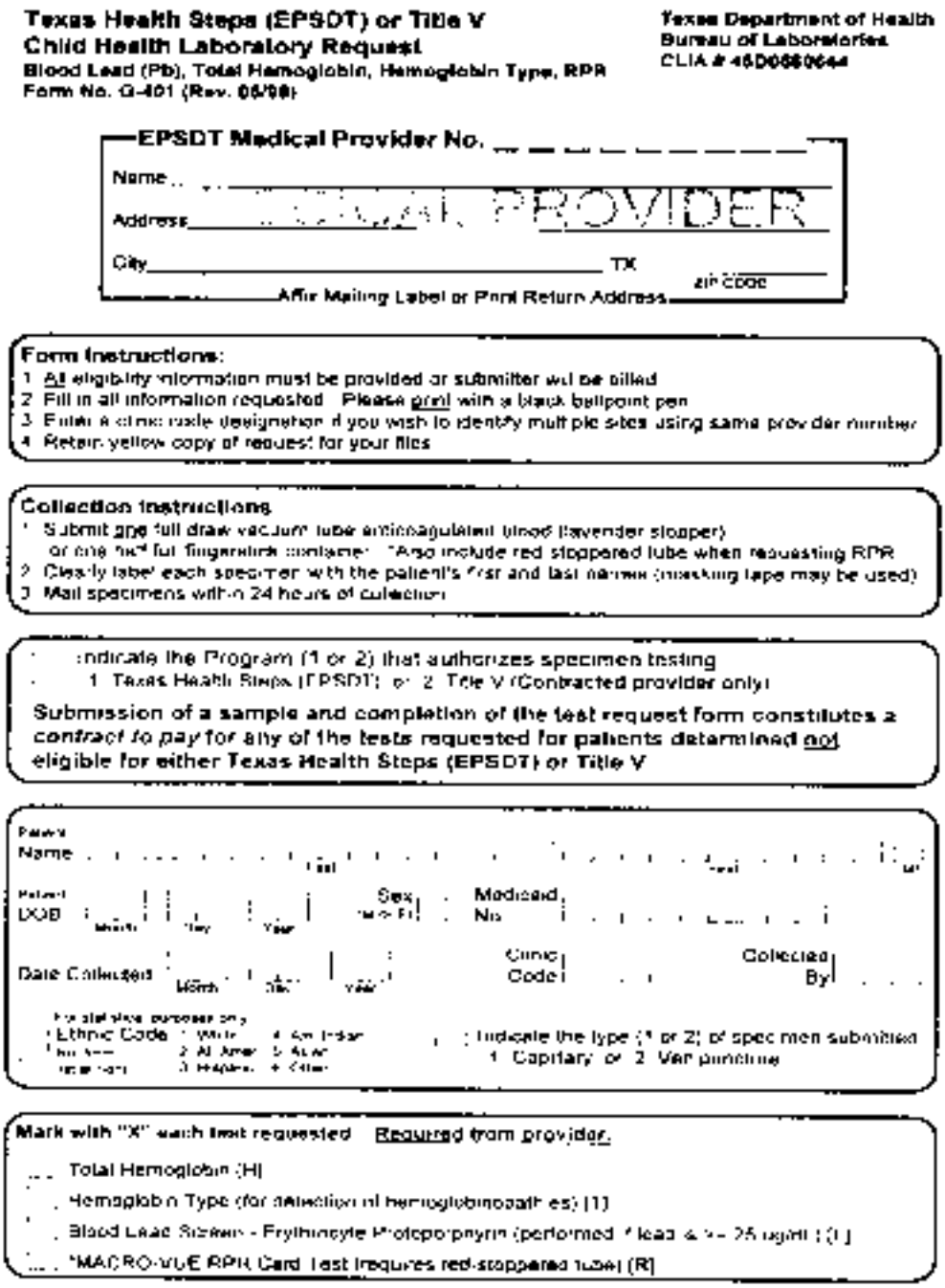
RECOMMENDATIONS

1 ❑ Repeat smear	4 ❑ Repeat 6 months	7 ❑ E.C.C.
2 ❑ Repeat p therapy	5 ❑ Colposcopy	8 ❑ Repeat mid-cycle
3 ❑ Repeat 3 months	6 ❑ Biopsy	9 ❑ Repeat p estrogen

Tech/Date _____

Q.C./Date _____ Pathologist _____

7.44 THSteps or Title V Child Health Laboratory Request TDH



Texas Health Steps (EPSDT) or Title V
Child Health Laboratory Request
Blood Lead (Pb), Total Hemoglobin, Hemoglobin Type, RPR
Form No. G-401 (Rev. 05/98)

Texas Department of Health
Bureau of Laboratories
CLIA # 45D0650644

EPSDT Medical Provider No. _ _ _ _ _ _ _ _ _ _

Name _____

Address PROVIDER

City _____ TX _____ zip code

Affix Mailing Label or Print Return Address

Form Instructions:
1. All eligibility information must be provided or submitter will be billed
2. Fill in all information requested. Please print with a black ballpoint pen
3. Enter a clinic code designation if you wish to identify multiple sites using same provider number
4. Retain yellow copy of request for your files

Collection Instructions
1. Submit one full draw vacuum tube anticoagulated blood (lavender stopper) or one "hot" full fingerstick container. *Also include red stoppered tube when requesting RPR
2. Clearly label each specimen with the patient's first and last names (masking tape may be used)
3. Mail specimens within 24 hours of collection

Indicate the Program (1 or 2) that authorizes specimen testing
1. Texas Health Steps (EPSDT) or 2. Title V (Contracted provider only)

Submission of a sample and completion of the test request form constitutes a *contract to pay* for any of the tests requested for patients determined not eligible for either Texas Health Steps (EPSDT) or Title V

Patient Name _____ (last) _____ (first) _____ (MI)

Patient DOB _____ (Month) _____ (Day) _____ (Year) Sex (M or F) _____ Medicaid No. _____

Date Collected _____ (Month) _____ (Day) _____ (Year) Clinic Code _____ Collected By _____

For statistical purposes only
Ethnic Code 1. White 4. Am Indian
2. Af. Amer 5. Asian
3. Hispanic 6. Other

Indicate the type (1 or 2) of specimen submitted
1. Capillary or 2. Vein puncture

Mark with "X" each test requested. Required from provider.

_____ Total Hemoglobin (H)
_____ Hemoglobin Type (for detection of hemoglobinopathies) (T)
_____ Blood Lead Screen - Erythrocyte Protoporphyrin (performed if lead ≥ 15 - 25 ug/dl) (L)
_____ *MACRO-VUE RPR Card Test (requires red-stoppered tube) (R)

7.45 THSteps Laboratory Request Texas Department of Health (Cholesterol)

EPSDT LABORATORY REQUEST
CHOLESTEROL SCREENING
FORM NO. G-72

Texas Department of Health
Department of Laboratories
CLIA # 45D0660644

EPSDT Provider No. __ __ __ __ __ __ __ __ __

Name _____
Address _____
City _____TX_____
Please Print Below with BALLPOINT PEN OR TYPEWRITER

Patient's Name

Last First

Patient's DOB

Year Month Day Sex (M or F) Medic-aid No.

Date Collected

Year Month Day Clinic Code

For statistical purposes only

Ethnic Code (No. from list at right)
1. White 2. Af. Amer. 3. Hispanic 4. Amer. Indian 5. Asian 6. Other

Instructions:

1. Submit one full red-stoppered tube.
2. Clearly label each specimen with the patient's first and last names.
3. Fill in all information requested on laboratory request form.
4. Enter clinic code letter, if necessary for differentiation of multiple screening sites.
5. Retain a copy of request for your files.
6. Mail specimens within 24 hours of collection.

☐

Indicate the number (1-2) for test desired from the list below:

1. Cholesterol screen (non-fasting specimens acceptable)
2. Lipid profile: **Available only to at risk patients - must be a fasting specimen.**

LABORATORY RESULTS:
(DO NOT WRITE IN THIS SPACE)
Cholesterol Screen:

	Patient		Desired
Cholesterol	_____	mg/dl	<170

Lipid Profile

	Patient		**Desired**
Cholesterol	_____	mg/dl	<170
Triglyceride	_____	mg/dl	30-190
HDL	_____	mg/dl	>35
LDL		mg/dl	<110

7.46 THSteps Laboratory Request Texas Department of Health (Gonorrhea/ Chlamydia)

EPSDT LABORATORY REQUEST
GONORRHEA/CHLAMYDIA
FORM NO. G-73

Texas Department of Health
Department of Laboratories
CLIA # 45D0660644

EPSDT Provider No. __ __ __ __ __ __ __ __ __

Name _____
Address _____
City _____TX_____
Please Print Below with BALLPOINT PEN OR TYPEWRITER

Patient's Name

Last First

Patient's DOB

Year Month Day Sex (M or F) Medicaid No.

Date Collected

Year Month Day Clinic Code

For statistical purposes only

Ethnic Code No. from list at right

1. White 2. Af. Amer. 3. Hispanic 4. Amer. Indian 5. Asian 6. Other

Instructions:

1. Collect cervical/urethral specimen with Gen-Probe collection swab supplied by TDH. See specimen collection kit for detailed collection instructions
2. Insert collection swab into the transport tube, snapping off shaft at score line. CAP TUBE TIGHTLY
3. Clearly label the specimen with the patient's first and last name.
4. Fill in all information requested on the laboratory request form. Enter the clinic code, if necessary for differentiation of multiple screening sites.
5. Retain a copy of request for your files.
7. Mail specimens daily. If specimen must be held, store under refrigeration (DO NOT FREEZE), but do not hold more than three days.

Laboratory Test Information
All specimens will be tested for gonorrhea and chlamydia.
Specimen Information

Enter the number from list below to describe specimen source.

1. Cervix
2. Urethra
3. Vagina
4. Conjunctival
5. Other: Please specify _____

LABORATORY RESULTS:

7.47 THSteps Laboratory Request Texas Department of Health (HIV)

EPSDT LABORATORY REQUEST
HIV TESTING
FORM NO. G-74

Texas Department of Health
Department of Laboratories
CLIA # 45D0660644

EPSDT Provider No. __ __ __ __ __ __ __ __ __

Name ______________________________
Address ______________________________
City ____________________TX__________

Please Print Below with BALLPOINT PEN OR TYPEWRITER

Patient's Name

Last | First

Patient's DOB

Year | Month | Day | Sex (M or F) | Medic-aid No.

Date Collected

Year | Month | Day | Clinic Code

For statistical purposes only

Ethnic Code No. from list at right

1. White 4. Amer. Indian
2. Af. Amer. 5. Asian
3. Hispanic 6. Other

Instructions:

1. Submit one full red-stoppered tube.
2. Clearly label each specimen with the patient's first and last names.
3. Fill in all information requested on laboratory request form.
4. Enter clinic code letter, if necessary for differentiation of multiple screening sites.
5. Retain a copy of request for your files.
6. Mail specimens within 24 hours of collection.
7. Provider should retain informed consent of patient for this test.

Laboratory Test Information

Specimens submitted for HIV testing are screened with an EIA procedure. A Western Blot confirmatory test will be performed on any positive EIA screening test.

LABORATORY RESULTS:
(DO NOT WRITE IN THIS SPACE)

HIV-1 EIA ❑ Non reactive ❑ REACTIVE: SEE ATTACHED WESTERN BLOT REPORT

❑ Unsatisfactory ______________________________

7.48 THSteps Laboratory Request Supplies Order Form

THSteps Laboratory Supplies Order Form Form G-399 Rev. 9/94

Provider No. EPSDT __ __ __ __ Name _____ Address _____ City _____ Tx _____	**Send Requests to:** **TDH** **Bureau of Laboratories** **1100 West 49th Street** **Austin, TX 78756-3194** **512-458-7661, FAX 512-458-7672**

Contact Person: _____

Telephone Number: _____DATE REQUESTED _____

QUANTITY	ITEM	QUANTITY	ITEM
	Vacuum tubes (anticoag.)		Mailing Container - Small
	Vacuum tubes (plain)		Mailing Container - Medium
	Fingerstick collector (anticoag.)		Mailing Container - Large
	22 ga. x 1” vac. needle (multi-draw)		Mailing Label - Postage Paid
	Needle holder		**Laboratory Request Forms**
	Lancets		Form G-401 Laboratory Request
	Gen-Probe Collector - Female		Form G-72 Cholesterol Screening
	Gen-Probe Collector - Male		Form G-73 Gonorrhea/Chlamydia Test
			Form G-74 HIV Testing

FOR TDH USE ONLY: APPROVED _____

Filled by _____ Checked by _____ Date Shipped _____ Entered in Computer _____ Date _____

7.49 TDH Requisition for Laboratory Supplies

TEXAS DEPARTMENT OF HEALTH

Warehouse Order No_____

REQUISITION FOR LABORATORY SUPPLIES

Texas Department of Health
Bureau of Laboratories
1100 West 49th Street
Austin, Texas 78756

ATTENTION:_____

Listed Supplies will be Shipped to Above Address

			For Warehouse Use Only
Warehouse Catalog Number	**DESCRIPTION**	**QUANTITY ORDERED**	**QUANTITY SHIPPED**
Date of Order:	Approved:		

I hereby acknowledge receipt of the above listed supplies from the Texas Department of Health. Division Approval:

Order Filled By: Date Shipped

Signature Method of Shipment:

Date Received Form No. 1643 (6-84)

DISTRIBUTION 1. White - Lab (DP) 2. Yellow - Acknowledgment 3. Pink - Warehouse 4. Goldenrod - Retained by Local Lab

7.50 Newborn Screening Collection Form

NEWBORN SCREENING - COLLECTION INSTRUCTIONS

Specimens should be collected on all newborns no later than the first discharge date or before 7 days for early detection of newborns.
A second screen is also required at 1-2 weeks if sick/premature see Rules. **CORD BLOOD IS NOT ACCEPTABLE.**

Spec. No. **98-** 005325

Yellow Copy - Submitter

TEXAS DEPARTMENT OF HEALTH Bureau of Laboratories

98- 005325

+98005325U

Name _____

Address _____

City _____ TX _____

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